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A STUDY OF THE CONTRIBUTIONS TO OPHTHALMOLOGY MADE BY OUR SOCIETY DURING THE LAST 31 YEARS.

By George M. Gould, M.D.,
Philadelphia, Pa.

READ AT THE MEETING OF THE AMERICAN OPHTHALMOLOGICAL SOCIETY, NEW YORK CITY, JUNE 27 AND 28, 1906.

In 1874 some of Dr. Wm. Thomson's patients discovered that accurate correction of ametropia cured their headaches, insomnia, vertigo, various nervous and psychic ailments, nausea, failure in general health, etc. Thomson told Dr. S. Weir Mitchell of the facts, and in 1874, 1875 and 1876 Mitchell and Thomson reported their cases in reputable medical journals. Again, in 1879, Thomson published a confirmatory report entitled "Astigmatism as a Cause of Persistent Headache and Other Nervous Symptoms." In 1875 Dr. R. Brudenell Carter, in his "Textbook on Diseases of the Eye," tells of a patient with headache, vomiting, and palpitation of the heart who was cured by a pair of spectacles. In 1882 Dr. G. C. Savage gave clinical proofs, and stated the broad truth that sick headaches, or "migraine," was caused by eyestrain. In 1883 Lauder Brunton announced that "migraine, or sick headache, is very frequently associated with, and probably dependent on, inequality of the eyes, either in the way of astigmatism, myopia, or hypermetropia." From this time forward many trustworthy clinicians—Hewetson, Ranney, Stevens, Martin, Gould, De Schweinitz, Hinschelwood, Toms, Callan, Stephenson and a hundred others have in varying degrees and ways reasserted the truth of this theory. If vomiting can be caused by eyestrain, other symptoms referable to diseases of the digestive organs may have a similar origin, and in 1888 I had found it so, and I began publishing reports of such cases. I have continued to do so ever since. In 1898 the general practitioners Stockton and Jones, and in 1903 and 1904 Stockton, give guarded but clear assent to the theory. In 1905 the president

of the American Medical Association says: "The subject is familiar to all. Who has not seen correction of errors of refraction relieve so-called bilious attacks, periodical vomiting, anorexia, indigestion, and other gastric symptoms? The cure of grave organic ocular defects relieves similar gastric conditions."

In 1904 a well-known and reputable American surgeon wrote and published these words: "A very large group of cases of intestinal fermentation is dependent on eyestrain. These cases are perhaps quite as often overlooked as any others, but as soon as we have all become familiar with the external signs of eyestrain fewer cases will get to the surgeon with the diagnosis of abdominal disorder. Those that I see are sent to the office most often with the request to have the appendix examined, because the distension of the cecum is apt to cause more pain than distension of other parts of the bowel, and attention is attracted to this region. If there are external evidences of eyestrain, these cases are referred to the ophthalmologist along with my cases of nervous dyspepsia and gastric neuralgia, and some of the most brilliant results that I have observed in any kind of medical practice have come out of the treatment that was instituted."

In 1903 an old and well-known medical journal said editorially that even obscure gastric symptoms demand gastrotomy—advice which would compel many millions of American citizens to have their abdomens opened at once.

Dr. Robert T. Morris, a general surgeon, in the *American Journal of Obstetrics*, May, 1906, says that in young women with uterine flexions, malpositions, ovarian neuralgias, etc., these conditions should be considered as symptoms due to peripheral irritation. The first of these peripheral irritations is eyestrain, and he advises a special examination and report by an expert oculist. If the irritation is due to eyestrain, neither of the lumbar plexuses will be hypersensitive.

There can be no doubt in the minds of serious men, whether lay or professional, that as a factor of general disease eyestrain is of transcendent importance. If we place the estimate at the lowest, there cannot be less than one-third of all Americans who are suffering from headache, neuralgia, functional nervous and mental disorders, such as neurasthenia, insomnia, depression, etc., reflex neuroses, "migraine," and functional disorders of some kind of the digestive system, all leading to inflammatory and organic lesions. Make it lower still and place the number at 20,000,000, and admit that any considerable proportion of these diseases may be due to eyestrain, and it is evident that a scientific yea or nay dictates the happiness, health, and even the life or death of millions.

Our society is named American and also Ophthalmological. What has been its answer to the inquiry? Has it decided the controversy or has it even wished or tried to do so? It is presumed that its members are those best fitted to answer and to judge. Only through ophthalmologists could the truth ever have been found, and as the entire lay world is fast coming to a knowledge

of, or at least a belief in, the theory, it would seem that scientific decision should be made.

Starting with the average date of the announcements of Thomson and Mitchell, 1875, the medical or scientific articles published in 31 years in the Transactions of the American Ophthalmological Society number 870, with subclasses as follows:

Classes.	No. of articles.	Percentage of all articles.
Operations	149	17.13
Extraocular diseases as causes of ocular disease	133	15.29
Tumors	122	14.02
Instruments	94	10.80
Traumatism	59	6.78
Congenital and other anomalies	55	6.32
Refraction as an unapplied science	26	2.97
Physiology	23	2.64
Glaucoma	23	2.64
Sundry inflammatory diseases	22	2.53
Therapeutics	21	2.41
Diseases of the lids	14	1.61
Sympathetic inflammation	9	1.03
Paralysis and paresis	8	.92
Refraction and heterophoria as related to ocular disease	8	.92
Malingering and hysteria	7	.84
Strabismus	6	.69
Physical optics	6	.69
Blindness	6	.69
Eyestrain as a cause of extraocular disease	3	.34
Winking	3	.34
Miscellaneous and unclassified	73	8.39
	870	100.00

It seems perfectly fair to regard these percentages as representative of the opinion formed during 31 years of experience of our most learned ophthalmologists concerning the unsolved problems of ophthalmology and the relative values of the different spheres of our work. Nothing could more plainly say to young men: "These are the comparative values of the different subjects you have to learn and to teach. If you wish for entrance to our society, if you wish teaching positions in your local hospitals, colleges and communities, if you wish consultation cases, if you wish our respect and our blessing, act as we act, spend your strength on these subjects as we do. If not, anathema! We consign you to the shame of Europe and of the medical profession; your progress will be stopped and your good name will surely pass into oblivion."

Take first the surgical aspect of the question. If we add to the

number of papers on surgical operations proper those which imply surgical procedures, we reach the following summary:

Cases.	No.	Per cent.
Operations	149	17.13
Tumors	122	14.02
Instruments	94	10.80
Traumatism	59	6.78
Strabismus	6	.69
	430	49.42

(If some of these articles do not pertain to surgery, they are more than offset by others, *e. g.,* on heterophoria, glaucoma, lid diseases, etc., which at least in part do concern surgery.)

Now, I, for one, deny most emphatically that 50 per cent. of ophthalmic practice is or should be of a surgical character. I think that 80 or 90 per cent. of the office work of American oculists is non-surgical. Surgery has undoubtedly a necessary share in our work, but it is small, and the part played by medicine, therapeutics, and prophylaxis is many times as great; the beneficial results in the relief and prevention of human suffering of these departments is hundreds of times greater than surgery. I judge that the glamor, the money-making, the fame-seeking of the surgical specialist have warped our professional judgment, have narrowed our usefulness, and have disgraced us in the eyes of scientific men. It has certainly blinded us so that we do not see our proper function in the general professional world. It has rendered us so bigoted and intimidated that we will not allow a paper on eyestrain as a cause of systemic disease to be read at our meetings however much members would like to do so. And yet, if we had any sense of humor left, the 122 papers read on tumors, when compared with our daily office work in eyestrain, would make us burst into jeering laughter. Were Mark Twain a physician he only could do justice to this generation-long tumoresque humoresque banality.

If we glance at the next largest class of papers, those on ocular diseases from extraocular sources—the antique "medical ophthalmology"—we find that in the estimation of our members for 31 years this aspect of our work is held to be something like 44 times as important for human welfare and professional progress as is that of the reverse—the ocular source of extraocular diseases. This, one may suppose, is in obedience to the irreligious beatitude, that it is more blessed to receive than to give. What pleasure we have had in assuring general physicians and non-oculist specialists that the eye is the meekest of all the organs of the body and we the meekest of medical babes! Eye and eyeman welcome the results of all the bad work and diseases they pour upon us, but the eye, that noblest, most delicate, most used, and most useful organ, can do no harm to others and will never cause any trouble to its hundred neighbors and masters. Now, I am certain that the future ophthalmologist will find, as many are now finding, that the cases

of systemic disease caused by eyestrain are not only not 44 times less, not only 44 times more numerous than the old medical ophthalmology of our members suppose, but are perhaps 4400 times as numerous.

Let us come to the heart of the matter. In 31 years there have been read before the society four papers pertaining to the extraocular diseases caused by eyestrain. One of these, however, was a charming argument against the theory. It reminds one of the story of that learned body of European medical men who gravely pronounced against the railroads then planned, and with vast erudition demanded that high board fences should be erected on both sides of the track. In this way, they said, those riding in the cars would avoid vertigo, sickness, and grave cerebral disease bound to follow from the rapid motion and changes of scene. Reduced to its essential elements, the proposition of the modern ophthalmic opponent referred to was that the counting of noses fixes the truth or error of a scientific theory. If the noses of the Royal College of Physicians of Bavaria had been counted, our railways would today be lined with high board fences, much to the increase, one judges, instead of the decrease, of dizziness and brain disease. And balloting, surely, was what killed poor Semmelweiss and his absurd theory of puerperal septicemia. In the same controversy Hodge and Meigs also had all the ballots with them and against the pitiful upstart, Oliver Wendell Holmes.

Among the thousand proofs of the invariable law that the "leaders," or supposed leaders, in any science never discover, and always oppose new discoveries, may also be adduced this, quoted by Dr. Croskey: "On April 6, 1705, in the Hospital of Doornik, Brisseau performed an autopsy upon a soldier. One eye of the corpse contained a simple ripe cataract, upon which Brisseau operated. He first made a depression of the cataract; he then removed the membrane which he thought to be the cataract, and upon examination he found that the pupil had its original black color. Upon dissecting the eye he found that the opaque lens was not in its proper position, but that it had been depressed into the vitreous. He reported his observation to the French Academy, which totally ignored his announcement, and one of its members (Duverney) advised him to keep his discovery to himself and not make himself the laughing-stock of the Academy."

In American ophthalmology "one toddled off and then there were three." But of these three one suggests no more than that eyestrain causes headache—nothing else. Another carefully limits the headache-producing cause to heterophoria, and, most frightened of all, the third tremblingly hazards the thought that in one case headache and chorea were "simulating" diseases, "just pretending earnest," as the children say, and that the choroiditis, which was possibly the result of ametropia, was really the cause of the head symptoms. At best it was the old story: "This is the rat that ate the malt that lay in the house that Jack built." Of course, the rat was murderously pounced upon. For example: "A

great many cases of astigmatism in young ladies of nervous temperament have been reported. A great many have come to me supplied with glasses of all kinds without being relieved. In the most of them I found sight, refraction, and accommodation normal. I have simply advised these patients general hygiene, and they have got well. To prescribe glasses to almost every patient that has not a coarse organic lesion seems to be so much the tendency of the day that very soon oculists will be called refractionists, as 25 years ago they were called iridectomists."

And not a protest was made against this arrant unscientific, inhuman, inexpert, plebeian, and positively vulgar nonsense. Never since, except once in discussion last year, has a member dared to write or speak in support of the truths which we all know are true—the truths that not by the ophthalmoscope alone, and especially without cycloplegia, can there be any accurate refraction; that glasses do often relieve the symptoms which no "hygiene alone" can cure; that the ophthalmology revealed in the quotation is a ludicrous travesty of genuine art and science; that it is precisely the low errors of refraction, "too slight to diagnose and too trivial to correct," which cause the most ruinous reflexes in the general system; that the recklessness of these truths and inexpertness in the art of refraction are filling the offices, near and far, of men with finer minds and skill who are rescuing from atrocious suffering those turned away by blunderful indifference, and, finally, that a man of healthy instincts would rather write 122 papers reporting sick headache or spinal curvature cured than 122,000 on melanosarcoma or cyst of the iris or 55,000 on colobomas and other curiosities.

But, as evidenced by the papers allowed to be read, the American Ophthalmological Society states to all young aspirants for membership, to all would-be teachers in medical schools and colleges, to the medical profession in general, that the theory that eyestrain can cause any extraocular disease except possibly, rarely, and doubtfully headache* is not even worth mentioning. It says that even headache as a result of eyestrain is scarcely worth a glance and a sneer; that operations are 50 times as important as the whole pother about eyestrain; that ocular diseases due to extraocular causes are 44 times as injurious as eyestrain; that tumors are 40 times as harmful as eyestrain; that the devising of instruments does 31 times the good to the world; that injuries are 20 times as frequent; that describing curious congenital anomalies is of 18 times the service to humanity than would be the possible relief of all the neurasthenias, headaches and other cerebral diseases, dyspepsias and vomiting of 20,000,000; that refraction solely to better vision is of eight or nine times more benefit than "the ocular-neurosis crank" could be; that physiologic problems should interest the curer of disease eight times more than all non-ocular diseases; that mere physical optics is a nobler study for medical men by two to one than all reflexes of eyestrain, and, lastly, that the mere fact

*And one member avows that frontal headache is due to the nose instead of the eyes!

of winking (*absit omen!*) is of greater suggestion and interest than all the dyspepsias, malnutritions, nervous disorders, and mental diseases that a hundred condemnable refractionists have ascribed to eyestrain. It seems a very topsy-turvy world, indeed, wherein we oculists live.

And sadly enough the upside-down and backside-to is bound to grow worse and more confusing! There are at least 15,000,000 or 20,000,000 American citizens suffering from eyestrain; a large proportion of these from the systemic effects of eyestrain, which are wrecking happiness, ambitions, life-work, and even life itself. All the cynicism and ignorings, all the denials, will not change the fact or hinder the recognition of the truth. The ophthalmologists and their societies pretending ignorance and assuming indifference are doomed. Hiding the head in the sand only invites more speedy and a more ignominious end of the animal, and end of the play.

Why is this absurd silence and this opposition to a truth which we all know to be a truth? At least three-fourths of the daily practice of ninety-nine one-hundredths of American oculists is made up of eyestrain problems and eyestrain work. The other one-hundredth are busy a big part of their time in turning away patients they are incapable of treating or have not time to treat, or, for other reasons, will not treat. Why must official ophthalmology pretend to ignore what practical ophthalmology works at all day long? Well, that, too, should be perfectly plain to all of us.

In the first place, official and authoritative science of any kind, and especially that of medicine, and especially the ophthalmic division of medicine, never discovered anything. They never even allowed any discovery to come to fruition except when forced to do so and after long years of cursings of the discoverers and promulgators by the so-called "officials" and the "authorities." Only a little knowledge of history and of psychology is required to make this evident. One of the funniest of the many funny methods whereby the blind authorities oppose new discoveries is by crying "exaggeration" and "hobby-riding," and all the time their own exaggeration and hobby-riding is so exalted (122 papers on tumors, 430 on surgery, etc.) that not to laugh requires an owl-like intelligence and an amazing ability to ignore illogicalities. These authorities and their methods are preoccupied with the sweet self-flattery of supposing themselves too broadminded and erudite to be "extremists" and "spectacle-peddlers," and all the time they are shining examples of "specialism gone mad," of "hobby-riding gone to seed," and all the rest of the pet expressions used so glibly.

It requires but a modicum of acumen to see that a most extraordinary laboriousness and conscientiousness, a highly exceptional delicacy and accuracy of mind and hand are required to master the problems of refraction and eyestrain. Those who have grown up in the surgery and organic-disease crudities of anatomic pathology cannot be expected to have the judgment, skill, and intellectual acumen required in the diagnosis and treatment of functional dis-

eases and in the deeper and finer problems of eyestrain and systemic disease. We may pity and excuse this in individuals, but our duty is not to them nor to the profession, but it is to our patients. Science and the profession may go hang; our duty is to cure and prevent disease by any right means in our power.

The crux of the matter is accuracy in diagnosing ametropia, judgment in prescribing glasses, and an enormous conscientiousness and zeal in getting the right spectacles rightly worn. It is not exaggeration to say that 50 percent of the refraction done by America's 5000 or more oculists is ludicrously incorrect and would not cure eyestrain. Then fully 50 per cent. of all opticians' work is so inaccurate in make and adjustment that failure must follow even with correctly ordered glasses. The spectacles get awry or their use is discontinued. Besides these things, the refraction changes in a couple of years; at least the old glasses become incorrect.

There is not a machine shop and scarcely any manufacturing establishment in the land in which infinitely greater skill and accuracy is not daily illustrated by common workmen than in the majority of the offices of the ophthalmic surgeons of the world. If our car axles were turned as blunderingly, our steam valves as imperfectly, if our dynamos and watches and scales, and a thousand instruments of precision were made with as amazing a lack of precision as the vast majority of the diagnoses of ametropia, we could not carry on our civilization for a day. The whole business would come to sorry smash. As a profession, as a civilization, we have not met the conditions demanded by the facts and demanded by the eyestrain cranks and hobby-riders. The sneerers and cynics of the eystrain theory are not so illogical as it would seem, for if they had done the accurate work which is demanded they would have had thousands of their cured and grateful patients demolishing the most inexpugnable and solidly-built systems of prejudice and "success."

And one of the strangest, yet inevitable, results of this is that the general physician knows and recognizes the truth better than the famous oculists, and the intelligent lay world knows it better than the medical profession. A well-known professor in a great university writes to me as follows: "Keep hammering at the general practitioner; perhaps sometime he will understand the reflexes caused by eyestrain. I, devoting all my time to internal medicine, have difficulty in compelling most oculists to bear me out in believing that eyestrain can cause so many disturbances." And our lay patients, sensible common people as well as educated literary workers, are more cognizant of the truth than the profession. They discovered it, not we, and they are today begging us to rediscover it. So evident has the truth become to the laity that the Governor of one of the greatest and best of New England States in his inaugural address says: "There are, to quote one line of work only,

children now struggling for education through pain, ailing little creatures, backward in their lessons, tortured with racking headaches, who only need relief of a complaining set of nerves by a pair of properly-adjusted glasses to transform them to healthy, happy children, capable of assimilating all the benefits of their school work."

I recently received a letter of indignant protest from one of the most famous of American physicians against a plan I had urged that all children should have their eyes carefully examined by expert oculists. In dentistry it is advisable; in ophthalmology it is specialism and extremism.

Dr. John G. Wilson of Montrose, Pa., in the *Journal of the American Medical Association,* May 19, 1906, thus hits his finger upon another ailing place. As to headaches due to eyestrain he says that "large numbers of school children go to their physician and are given headache remedies without end. This is to no purpose, and they finally have to give up school on account of becoming nervous wrecks, unless by chance they happen into some jewelry store and are given some kind of lenses to wear which may relieve the trouble to some extent. The country physician, therefore, should take up refraction work. The great mass of working-people simply cannot pay the fee demanded by the oculists, and are forced to put up with the indifferent work of the so-called opticians. Two or three hundred dollars will buy the necessary equipment and a month's work in some eye infirmary will give one a start, and one can do as well at once as any optician will ever be able to do."

As a profession and as specialists we have not raised one finger to prevent or to undo the deep disgrace hinted in these lines. There is not a single adequate, serious school of refraction in the world, nor is there a sign that one is coming. Yet such a school is more needed and would do more good than all the ophthalmic departments in all the medical colleges and hospitals of the world.

Moreover, there are at least 15,000,000 American children and adults afflicted with lateral curvature of the spine. All the smiles of incredulity will not, alas! lessen the number nor the horror of the consequence of the abnormalism. There is no existing machinery, no care or solicitude to prevent the sufferings nor to prevent the very existence of these millions of scoliotics. The defect arises unknown and unsuspected by physicians and by orthopedists. When it is incurable the orthopedist learns of a few of the cases. Surely over 90 per cent. of these scoliotics owe their tragedies to ocular molfunction readily demonstrable and its results always preventable. Two months ago, for example, a child of five years of age was brought to me with many complaints—vomiting of food, peevishness, ill-health generally. A nurse and a physician were retained as constant attendants of the child. I found a grade of astigmatism so low that great authorities in this society publicly to the profession and daily to their patients state that it is useless to correct it. Both axes of this astigmatism were 105°—a defect that

produces head-tilting and spinal curvature. The child had both. Glasses were applied, and since then the incipient spinal curve has disappeared, there is no vomiting, no drugs are required, there is steady gain of weight, there is complete return to normal health. What would have been the life-history of this little one had it fallen into the hands of the "ophthalmic surgeon" who scorns the refractionist, who sneers at functional and beginning disease, who does his refraction with the ophthalmoscope and without a mydriatic, who loves surgery 50 to 500 times as much as he does the prevention of disease, who loves surgery 5,000,000 times as much as he loves the prevention of surgery, who is 40 or 100 times more interested in a sarcoma or an osteoma or a coloboma than in the headache and vomitings and "neurasthenias" and suicides of his patients?

At present we oculists are most busy and earnest, and effectively so, in creating "fake" ophthalmic and refraction schools, refracting opticians, peripatetic spectacle peddlers, and quack M. D. oculists. These things are the direct result of our neglect, our bigotry, our money-making, and our pseudoscience. At present osteopathy is influencing legislatures, and ignorantly, but far more successfully than many of the profession, it is treating the millions of distorted or weakened and diseased backs of our people. We neglect the study of the spinal column utterly and wholly in the functional and beginning stages of lateral curvature. Osteopathy is a product of our professional neglect and bigotry, and especially of the ophthalmic variety. Eddyism is rampant in the land, and as professional blunderers and sinners we are to a great extent responsible for Mrs. Eddy and her foolish children. By our policy of ignoring and self-satisfaction we are absolutely the creators of quack refraction, osteopathy and faith-cure, and half of this professional blunder is due to ophthalmologists.

P. S.—The program of the 1906 meeting of the society emphasizes the lessons drawn in the paper:

1. There are only 27 papers upon the program, illustrating the truth that the old subjects have had all the juice sucked out of them long ago. Conservatism and Zeitgeist still dominate.

2. The discussion on the papers dealing with bacteriology and purulent ophthalmia ends in the old truth that frequent irrigation with pure water is of as great value as the germicides.

3. Tumors, curiosities, and anatomic pathology still occupy the major part of the attention. The influence of hospital and dispensary practice outweighs all else.

4. There is not a paper in the program dealing with any phase of eyestrain.

5. The single paper that, from the reputation of the writer, might be suspected of heresy is placed by the committee as the last bristle on the end of the tail of the program.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

BALTIMORE CITY MEDICAL SOCIETY.

The annual meeting of the Baltimore City Medical Society was held at the Faculty Hall, Tuesday evening, December 4, 1906, at half-past eight.

In the absence of the president, Dr. Thayer, and the vice-president, Dr. Neff, the meeting was called to order by the secretary, Dr. Magruder. Suggestion was made that Dr. Woods be asked to preside for the evening. The motion was made by Dr. Harlan and carried.

Dr. Harlan reported on behalf of Committee for Prosecution of Unregistered Physicians, and stated the difficulties he had in prosecuting the offenders, even when the case seemed perfectly clear. He also read a number of interesting letters which had been written him.

Dr. Earle moved that the report be accepted and the committee be continued. Dr. Winslow seconded the motion and stated that he also thought the committee should be continued.

Dr. Reik mentioned the fact that Dr. Harlan had really done most of the work.

The motion was carried.

Report of Board of Censors by Dr. Brack, chairman, as follows:

ANNUAL REPORT OF THE BOARD OF CENSORS.

"A canvass has been made of the physicians, not members of the society, by medical schools from which the lists were obtained. Over 200 endorsed application blanks were sent out, and 90 personal letters, to recently-licensed physicians, enclosing return postal cards for correct address. To these letters but 21 replies were received and no applications.

"Forty-two applications were received by the board and passed upon. There has been one rejection.

"Of the 42, 33 were elected at the semi-annual meeting in April and nine will be presented to the society tonight—Drs. L. E. Beach, L. A. Goldbach, N. M. Owensby, A. Palmisano, S. T. R. Revell, R. P. C. Scheidt, G. W. Simpson, Alfred Ullman and O. E. Janney.

"Dr. O. E. Janney is not fully endorsed by the board, but is presented to the society so that the momentous question of admitting homeopathic physicians can be determined by general vote and a precedent established.

"This question has exercised the board very much, and in our previous report we requested the society to express its opinion; as this was not done, we are now presenting a test case.

"According to our by-laws, any physician practicing or supporting sectarian medicine is debarred from membership. Dr. Simmons, secretary of the American Medical Association, states that the matter is left to the discretion of the individual society.

"Whether membership in a homeopathic society can be construed to mean supporting sectarian medicine is the question in Dr. Janney's case, for the doctor states that he is not otherwise affiliated with homeopathy, but declines to resign from the homeopathic society.

"It is therefore left to your decision by general vote to establish the status of homeopaths seeking entrance into our ranks.

"The board fully appreciates the personal qualities of Dr. Janney as a man and as a physician and is favorably inclined to Dr. Janney's admission, but as any action would mean either to open or shut the door, we prefer to have the society make its own decision.

"For the past six months the board has been engaged in investigating certain grave charges against one of its members, and I feel that, in justice to the man, a statement should be made before the society that the evidence does not substantiate the charges. It is admitted that the member in question has been indiscreet in criticising the actions and ability of some of his fellow-practitioners and this indiscretion has been censured.

"The evidence indicates that many of the rumors can be traced to the pernicious activity of a former patient, who is undoubtedly unbalanced mentally. The same woman has made charges against other physicians and hospital residents."

Dr. Winslow made a supplementary report, in which he spoke of Dr. O. E. Janney and recommended him as a desirable member.

Dr. Woods called upon Dr. R. C. Cabot of Boston to state the attitude in Boston toward homeopaths.

Dr. Cabot stated that in Boston the bars had been let down, but that the homeopaths were obliged to pass the same State Board examination as the regular physicians.

Dr. J. D. Blake stated that if we intend to do as we claim—admit reputable homeopathic physicians to membership—that we should so express ourselves in voting on this member.

Dr. Earle announced that he had made a fight along this line during his term as president of the Faculty, and that he was very much in favor of admitting desirable homeopathic physicians who were otherwise qualified.

Dr. O'Donovan said that he had attended college with Dr. Janney and

had known him ever since; that his opinion of him was that he was a man above reproach.

Dr. Rowland, a member of the Board of Censors, desired to put himself on record as personally having nothing against Dr. Janney, but that the Constitution of the Baltimore City Medical Society plainly disbars anyone supporting sectarian medicine, and it is the duty of the city society to construe this clause.

Dr. A. K. Bond thinks we should announce to the public the grounds on which we stand.

Dr. Ruhräh thinks we should have a general meeting of the Faculty to discuss this subject, as it is far-reaching and important.

Dr. Winslow again expressed himself as believing that the time had come for admitting homeopathic physicians who come under the requirements, and that Dr. Janney is certainly a most desirable man.

Dr. Brack stated that personally he was very much in favor of admitting Dr. Janney as a man, but that he felt, as a member of the Board of Censors, that the clause in the Constitution relative to sectarian medicine makes him hesitate to recommend him without placing the responsibility on the Baltimore City Medical Society.

Dr. C. U. Smith expressed himself as thinking that any man affiliated with a homeopathic medical school or homeopathic medical society must necessarily be classed as sectarian.

Dr. Earle moved that the report of the Board of Censors be accepted and ballot taken. Carried.

Drs. Reik, Futcher and O'Donovan were appointed tellers.

A short talk was given by Dr. Ruhräh, entitled "Pruritus Publicitati." His remarks were based on newspaper clippings concerning members of the Faculty in the city and State, which had been collected during the year and filed in a scrapbook.

Dr. Reik announced that the entire list of candidates for membership had been elected. Those on the list were as follows: Drs. L. E. Beach, L. A. Goldbach, O. E. Janney, N. W. Owensby, A. Palmisano, S. T. R. Revell, R. P. C. Scheidt, G. W. Simpson and Alfred Ullman.

Dr. Reik moved that the election of officers be postponed and that Dr. Cabot be called upon to read his paper. Seconded by Dr. Magruder and carried.

Dr. R. C. Cabot's paper was entitled "Suggestions for hospital reorganization, with special reference to a greater effectiveness of treatment therein."

Dr. Taneyhill moved that a rising vote of thanks be tendered Dr. Cabot. The motion was unanimously carried.

Dr. Earle, chairman Nominating Committee, reported the following nominations:

President—Dr. A. C. Harrison.

Vice-President—Dr. J. M. Hundley.

Secretary—Dr. W. E. Magruder.

Treasurer—Dr. W. S. Gardner.

Censor, new member of Board—Dr. C. E. Brack.

Delegates to Faculty to fill three vacancies—Drs. J. H. Pleasants, J. W. Holland, H. M. Fitzhugh.

Dr. Winslow moved election. The motion was seconded and carried.

The meeting adjourned.

SOME FEATURES OF LEPROSY.

By Dr. Percy S. Rossiter,
Past Assistant Surgeon U. S. Navy.

PAPER READ AT THE SEMIANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY AT ANNAPOLIS, MD., SEPTEMBER 27-28, 1906.

At the time I was honored by the request of your secretary to present a paper at this meeting the press of this and several neighboring States was revelling in the delights of attracting the attention of its readers to the horrors of leprosy, and startling them with the fact that a leper had appeared in the community; whereupon several large corporations—and I fear several Boards of Health—came very near being stampeded, because they became alarmed at a name, and failed to recall the fact that of all the contagious diseases leprosy is the most difficult to transmit.

As leprosy is, fortunately, an extremely rare disease in this part of the world, and a large majority of our profession rarely, if ever, see a case of it, and as I have recently been more or less intimately associated with the disease and the manner in which it is handled in Hawaii, where it is very common, I decided to present a brief paper on the subject of leprosy.

Unfortunately, I have nothing new of any value to present to you either in respect to the etiology or treatment of the disease; in fact, since the discovery of its cause, the Bacillus leprae, by Hansen, in 1874, very little advance has been made in the etiology and possibly less in the treatment.

Let us first recall briefly the history of the disease. The oldest Indian, Syrian, Chinese, and Egyptian writings mention a disease which, from their description of its terribly disfiguring character, prolonged and finally fatal course, lead us to believe that what we now describe as leprosy, and what the Biblical and profane historians of the early Christian era describe as "the unclean," was a common disease in Oriental countries from the remotest times.

The exact date of its introduction into Europe is unknown—probably about 350 B. C., as Aristotle is the first Greek writer who mentions it.

The conditions, both political and social, favored its spread, and it invaded the whole continent, until in the Middle Ages the most strenuous forms of isolation and segregation had to be adopted to check its ravages. It then began to decline in Europe, the last case in Great Britain dying in 1798, until at present the only European country where there are any appreciable number of lepers is in Norway, where there are about 1000 cases.

Geographically, leprosy is a widespread disease, although it flourishes only in the backward countries, which are those where overcrowding and filth and the total absence of sanitation as it presents itself to the Caucasian mind of today present the conditions for its spread.

China leads in the number of lepers, both actual and proportional, with India a good second. It is also found in fairly large numbers in the Philippines, the Malay peninsula, the Pacific

islands (particularly the Hawaiian Islands), in North and South Africa, Arabia, Australia, Canada, Iceland, Siberia, South America, Mexico, and a few cases in the United States.

I do not intend to enter into any description of the symptoms of the disease, as you are doubtless all familiar with the literature of the subject and with the various types—the nodular leprosy, nerve leprosy, except seventh nerve, and the mixed type.

What I particularly wish to bring to your notice is the status of the disease as it exists in Hawaii, the manner in which it is handled by the local Board of Health, and some of the conditions which seem to me to be prime requisites for its spread.

Leprosy was probably introduced into the Hawaiian Islands by the Chinese in 1848. The disease spread rapidly, so that in 1865 there were 230 lepers in a population of 67,000. In 1891 the native population had been reduced to 44,000, of which 1500 were lepers, and at present about 1 in every 28 of the native population is a leper. This leper community also numbers among its population Chinese, Portuguese, and whites.

The leper colony is situated at Kalaupapa, on the island of Molokai, about 60 miles by water from Honolulu, which is on the island of Cahu. It is situated in a fertile valley on the beach, and is practically cut off from the rest of the island by an almost impassable cliff 1000 feet high.

In this community the lepers have their homes, their farms, schools, churches, and with the exception that communication with the outside world is prohibited, and that food and clothing are supplied them by the Territorial Board of Health, they live the life of the ordinary native villagers. There is a resident physician employed by the Board of Health, and the president and members of the Board pay regular visits to the colony.

Throughout all the islands the Board of Health employs physicians to keep a careful watch on their districts for new cases of leprosy, especially in those families who have had leprous members or intimates.

As soon as a suspicious case is discovered it is sent immediately to Honolulu and placed in a detention camp outside the city, which is decently furnished, well kept, and carefully guarded.

Here a number of cases are kept for a time under the daily observation of the secretary of the Board of Health, who examines them from time to time in search of the Bacillus leprae. This is done in the following manner: A bit of skin is snipped with a pair of scissors from a suspicious locality, usually at the base of the nose, dropped into a small vial and labeled. This is taken to the laboratory and thoroughly macerated in an agate mortar with sterile water. A smear is then made from this pulp and stained by acid fuchsin, decolorized with weak acid, and counterstained with methylene blue. The bacillus being an acid-fast organism, almost identical in appearance with the Bacillus tuberculosis, appears as a slender red bacillus in a blue field.

After a patient has been sent to the suspect camp he is examined by the so-called "Leper Board," appointed by the Governor, which consists of from five to seven physicians. After a positive

diagnosis has been made by the Board, never until the Bacillus leprae has been demonstrated, the patient is committed to the leper colony. In case of failure to make a positive diagnosis the patient is returned to his home and a careful watch kept on him by the local representative of the Territorial Board of Health lest he later show other symptoms of the disease.

Many instances are known where one member of a family becoming a leper the wife or husband, or at other times near relatives, wish to accompany them to the leper colony and pass their days there. This permission is occasionally, though rarely, granted. These persons usually eventually become lepers.

Regarding the transmission of the disease, we do not know the exact manner of its transmission. As it is a bacterial disease, there must be a specific time and route when and by which the bacterium first enters the body.

Sticker found the organism in the nasal mucus of a large percentage of cases, and concludes that the disease is primarily an ulcerative process of the nasal septum. The frequency with which the organism can first be demonstrated in the thickening in the skin at the root of the nose lends color to this theory.

Apparently the most intimate personal contact with a leper is necessary in order to acquire the disease. It also seems that conditions of filth and squalor and a semicivilized mode of life are almost essential to its transmission.

In Hawaii no white man, living the life of a white man, has ever acquired the disease. In every instance where the disease has been acquired by a white man he was living with a native wife or in a native family, living the life of a native.

In localities where the conditions favorable to its transfer exist the disease becomes widespread. It spread with alarming rapidity over Europe and Great Britain in the eleventh and twelfth centuries, but if we pause and consider what the sanitary and social conditions were in even the best of European countries at that time we cannot be surprised at its spread, for there is scarcely in the world today a savage who lives under the filthy and insanitary conditions of our own boasted ancestors of 600 years ago.

The white man of today does contract leprosy, but rarely, indeed, where he lives the life of a white man. The medical practitioners in Hawaii handle leprous patients in their offices apparently with impunity.

One of the chief stumbling-blocks in our path in endeavoring to trace the method of infection in leprosy has been the fact that as yet no wholly successful result has been obtained in growing the organism on artificial media. There is a possibility, to my mind, that in view of the extremely long period of incubation in leprosy (2 to 25 years) the growth of the organism must be very slow indeed even in the body, and that possibly a sufficient time has never been allowed for it to develop on artificial media.

Leprosy may probably be transmitted by direct inoculation. The experiment made in Hawaii, in which a condemned criminal was inoculated by making an incision in his forearm and inserting a portion of a leprous tubercle excised from an undoubted case of

the disease, then suturing the tissues in place again, is occasionally doubted because of the short incubation period which preceded the onset of the disease (one month), and because of the fact that members of his family were lepers. However, in this case the first symptoms of the disease made their appearance at the identical point of inoculation. Two years later the man was a confirmed leper, and died of the disease in six years.

Various insects have been accused of transmitting the disease—fleas, bedbugs, lice, and mosquitoes. As a matter of fact, we have no positive knowledge as to the means of its transmission.

I have not heretofore mentioned heredity as a cause, for I believe actual heredity is no longer accepted by any recognized authority as the means of transmission, for too many cases are on record where the victims could not possibly have had leprous ancestors and many cases where leprous parents gave birth to healthy children. Most of these children, if removed at once from the infected surroundings, never become lepers.

Hansen has shown that of the numerous progeny of 160 Norwegian lepers who emigrated to America not one has become a leper.

Lepers should be isolated or segregated wholly from the rest of the community, and no direct contact either of their persons or of articles handled by them should be allowed with those not infected with the disease. But the mere fact of a leper having passed through a community does not mean the spread of the disease.

I do not intend to enter into the treatment of the disease. About every drug known to man has been tried, with little or no beneficial result. Occasionally all symptoms disappear from a case for months and it is heralded as a cure by some particular method of treatment, but so far every case thus cured has always sooner or later suffered a recurrence. The hot-mud baths practiced in Japan as a treatment for leprosy seem to give more beneficial results than any other method.

Personally, I believe we have only one way to look for hope for the leper, and that is toward serum therapy. Carasquilla claims to have obtained encouraging curative effects from serum from horses immunized by injecting them with a filtered culture of the growth which he claims to have obtained in bouillon.

However, considering the elaborate scale on which experiments are to be made by the Federal Government under the direction of the United States Public Health and Marine Hospital Service in Hawaii, a better knowledge of the disease may be looked for in the near future.

One square mile near the leper colony on Molokai has been ceded to the United States by the Territory of Hawaii, on which are now being erected the various buildings to be used in prosecuting the search for a cure. This station is to be equipped with the best appliances and the best brains that our day affords, and I believe we can confidently look forward to a much fuller knowledge of leprosy, etiologically and from a prophylactic and curative standpoint, in the coming five years.

SOME OF THE RECENT ASPECTS OF QUARANTINE AND ITS RELATION TO PUBLIC HEALTH.

By M. J. Rosenau,

Past Assistant Surgeon and Director Hygienic Laboratory, U. S. Public Health and Marine Hospital Service, Washington, D. C.

PAPER READ BEFORE THE MEDICAL AND CHIRURGICAL FACULTY AT THE CITY QUARANTINE STATION, APRIL 25, 1906.

QUARANTINE may be likened to jails, penitentiaries, houses of correction and other necessary evils of this world. The very absurdity of the word quarantine, coming from the Italian "quaranta," meaning 40, is an indication that we are dealing with a condition resulting from an imperfect social fabric.

It does not take a prophet to foresee the time when society will be developed to that state of civilization and the sanitary sciences will have reached that point of excellence where restrictive quarantines will be entirely unnecessary. But the millennium is a long way off, and we will see little abatement of quarantine restrictions in our day and generation.

In the Middle Ages, when the Hanseatic League of cities held their commercial supremacy, we learn that Venice detained ships arriving at that port with cases of pestilence aboard for a period of 40 days. While isolation and detention had been practiced to a certain extent prior to that time, this was the first instance of the systematic application of maritime quarantine methods, and they have survived in a modified form to this day. Since then in addition to maritime quarantines we have land quarantines, interstate quarantines, municipal quarantines, house quarantines, cattle quarantines, and quarantines for revenue only. Some of these, especially municipal and interstate quarantines, have developed to large proportions, so that they are now replete with intricate medico-legal problems and have become highly specialized, like other branches of the medical sciences.

Today we shall confine ourselves to a discussion of some of the problems of maritime quarantine, and I shall take this opportunity to express some stray thoughts upon the underlying principles governing the federal quarantine service, giving some of the recent developments in quarantine methods, and finally pointing out a few of the lessons to be learned from the late epidemic of yellow fever in New Orleans.

THE FEDERAL QUARANTINE SERVICE.

It may be interesting to those not familiar with the principles underlying the organization and methods used by the Public Health and Marine Hospital Service in its maritime quarantine work to hear the story, briefly told, of how the Government protects its citizens.

The object of maritime quarantine is the protection of a country

against foes often more deadly than those of war. It is a coast defense against exotic pestilence. We do not quarantine against tuberculosis, scarlet fever, malaria, typhoid fever and other serious contagions which, like the poor, are always with us. We only guard against the invasion of such strangers as, once introduced, might work havoc in our midst. In view of this fact the Federal Government recognizes but six quarantinable diseases: Cholera, yellow fever, plague, typhus fever, smallpox and leprosy.

Some diseases, for instance, relapsing fever, have been stricken from the list of quarantinable diseases, while the quarantine restrictions against others have been very much lightened within recent years. Epidemics of relapsing fever require the sum total of evil sanitary conditions, including overcrowding, poor and insufficient food, vermin, etc. These conditions do not exist in a sufficiently high degree even in the slums of our centers of population to favor the spread of this disease. Only last winter cases of relapsing fever were admitted into one of our large seaport cities and treated at one of the general hospitals without any more danger to the city than a case of rheumatism.

Our seaports in the yellow-fever zone could render themselves equally secure against yellow fever, and would not then fear to admit cases of that disease, as Havana has done for several years. Another instance of the lightening of quarantine restrictions is that we now no longer detain the vessel itself on account of infection. After proper measures of disinfection, or the extermination of mosquitoes, rats and other intermediate hosts, has been accomplished, the vessel with its cargo is permitted to dock, while the personnel is detained at the quarantine station. The introduction of this practice has saved commerce a certain amount of loss and delay. Restrictive measures regarding typhus fever are no longer so stringent as they formerly were. With the comparative degree of improved sanitation of most of our seaports there is little danger of typhus fever occurring in epidemic form. Therefore, if a vessel in good sanitary condition arrives with a case of typhus fever aboard, and the patient has been isolated and other measures taken to prevent its spread, only the patient is removed, the sick bay purified, and the vessel with all its cargo, crew and passengers permitted to land. With the increase of our knowledge of the causes and methods of transmission of the epidemic diseases our quarantine methods are not only more precise, but may now be carried out with every assurance of success.

I have called maritime quarantine a coast defense. The likeness is stronger than a mere figure of speech. At one time countries tried to build an impassable barrier against the quarantinable diseases which they feared, but all such systems of quarantine, like the great wall of China, are doomed to failure. The principle underlying the modern system of quarantine consists in fortifying the strategic points along the coast with a complete armament composed of lazarettos, barracks of detention and observation, disinfecting apparatus, wharves and vessels, and laboratories for

the detection of suspected disease. In addition to these quarantine fortresses, which are the backbone of our line of defense, our country, having such a long littoral, must also have a flying squadron consisting of a floating disinfecting plant, a traveling laboratory, and trained officers and men to concentrate quickly upon any particular point of attack.

The Federal Government operates several floating disinfecting plants, kept at favorable places, is equipped with two traveling laboratories, and has officers trained to make scientific diagnoses of suspected cases. It also has officers who have had long and valuable experience in practical disinfection and the management of epidemic disease. All these forces may be concentrated upon any given point with little loss of time.

Another principle underlying the quarantine defense at small and remote ports is an inspection service. Many small ports, having little communication with foreign countries, are not visited by quarantinable diseases for years. It would be manifestly poor policy and exceedingly expensive to maintain at all of these minor ports the cumbersome and complicated equipment necessary at a large and busy port to meet such infrequent emergencies.

At certain of our ports we concentrate this work at favorable places, known as "stations of refuge." These places are usually situated upon islands along the highways of ocean trade, and serve as detention, disinfection and quarantine stations for a number of coast cities.

THE LIMITATIONS OF DISINFECTANTS.

Disinfection is no longer regarded as the panacea that it formerly was. There can be no doubt that at one time we had an exaggerated notion of the powers and proper sphere of disinfection in sanitary work. I do not mean to belittle the great value of disinfection and disinfectants in preventing the spread of communicable diseases caused by bacteria. We now know, however, that most bacterial parasites causing communicable diseases which occur in epidemic form in man are not very long-lived, but usually die spontaneously within a comparatively short time.

We have further learned that infection is probably more often carried by means of mild cases or through the medium of a third person than by means of infected objects. For instance, the diphtheria bacillus may be in the throat of persons enjoying good health. When we learned that many communicable diseases are transmitted from man to man through intermediate hosts, especially insects and domestic animals, we found that ordinary disinfectants were not nearly so valuable as insecticides.

Sulphur dioxide still remains one of the oldest and the most valuable of our disinfecting agents. It destroys all forms of life, both vegetable and animal.

Formaldehyde gas is seriously limited in this respect, as it has little if any toxic action upon insects and higher animals. It is, however, exceedingly poisonous to bacteria; but even in this regard it has further limitations, for it is not effective when used

in cold or dry weather. Passed Assistant Surgeon T. B. McClintic, who worked in the hygienic laboratory under my direction during the past year on this question in relation to car sanitation, has drawn the conclusion that formaldehyde gas, no matter by what method it is evolved, is useless as a disinfectant provided the relative humidity in the atmosphere is less than about 65 per cent. and the temperature below about 60 degrees C. In other words, in cold or dry weather formaldehyde cannot be depended upon.

SANITATION THE ONLY CURE FOR QUARANTINE RESTRICTIONS.

The necessity for quarantine arises from the lack of sanitation. If all communities, especially seaports, were to place their cities in the best sanitary condition, in accordance with the teachings of modern science, there would be little danger of disease spreading to epidemic proportions, and practically no need of quarantine restrictions. Modern sanitation is very expensive. It means thorough drainage, proper disposal of wastes, good paving, pure water, and cities constructed with sufficient "breathing spaces" between houses so that all the inhabitants may receive their proper proportion of fresh air and sunshine. It also includes the destruction of mosquitoes, rats and other vermin which help to spread disease, and a proper supervision of the food supply.

This thought, which has been so often and so ably advocated by Surgeon-General Walter Wyman, is the great basic principle which actuates the Public Health and Marine Hospital Service in its sanitary work. In line with this principle the Surgeon-General has many times urged upon the neighboring Central American republics, and other governments with which our country has intimate commercial relations, to take steps looking to a solution of the problems affecting the health of coast cities. Prompted by this teaching, one of these countries, Honduras, has recently requested that an officer of the Public Health and Marine Hospital Service be detailed to take charge of its sanitary measures.

Our own cities in the yellow-fever zone might well take the lesson to heart by exterminating the *Stegomyia fasciata,* and so insure their cities against epidemics of yellow fever.

As an outgrowth of this line of action the Government has developed what may be termed a prophylactic quarantine; that is, measures are taken at the ports of departure to prevent ships from becoming infected. Medical officers of the service are stationed at seaports in all parts of the world where danger exists of conveying cholera, plague and yellow fever to the United States through the medium of ocean traffic. The officers at these foreign ports issue the bill of health to the departing vessel, supervise the loading and the embarkation of passengers and crew so as to ensure that no disease is taken aboard either in the cargo, the food, water or among the personnel. When necessary the ship is detained for disinfection or other measures at the foreign port to render it safe from a quarantine standpoint. These foreign

inspections relieve ocean travel of many annoying quarantine restrictions and are a potent factor in safequarding the health of our country. Those who appreciate the important service rendered by this foreign inspection hope to ensure its continuance through legislative enactment.

Maritime quarantine to be effective must be uniform and centralized, for a chain is only as strong as its weakest link. Viewed broadly, maritime quarantine concerns the Federal Government in much the same way as does the enforcement of the revenue laws; and, further, it must be regarded as the duty of the Federal Government to protect the health of its citizens against the introduction of foreign germs, just as it protects us against the invasion of foreign foes.

It is only in the enforcement of maritime and interstate quarantine that the Government is legally concerned, and sometimes feels the embarrassment resulting from the divided responsibility owing to the present imperfect laws. The central government never can and never will take the place of the State and local health authorities, for municipal and State sanitation are local questions. In fact, there is greater usefulness than ever for State boards of health and municipal health officers.

The Federal Government, through its system of co-operation with State authorities, is the medium by which local sanitary measures throughout the country are co-ordinated. These meetings between State and federal sanitary authorities are helpful in encouraging active sanitation, and are further helpful toward uniformity in the health laws and administration throughout the country.

RECENT YELLOW-FEVER WORK AND ITS LESSONS.

That it is possible to exterminate the yellow-fever mosquito in a large community in a comparatively short time was satisfactorily demonstrated last summer at New Orleans. The sanitary work in New Orleans was marked with such success because it concentrated almost its entire energies upon two points: (1) The screening of the sick, and (2) the destruction of the mosquitoes.

Those who have been in New Orleans in ordinary times need not be told of the unendurable extent to which the city was pestered with mosquitoes, particularly the *Stegomyia fasciata*. The fight against the mosquito, under the personal direction of Surgeon J. H. White, was so successful in New Orleans that when we arrived there in September we had the greatest difficulty in finding the *Stegomyia fasciata* at all, and it was only after setting many traps in many parts of the city that Passed Assistant Surgeon Goldberger and myself were able to secure enough of them to breed for our laboratory work.

Now that we have come to the subject of yellow fever I think it will be profitable to review some of the recent advances in the study of this disease which have a bearing on quarantine and sanitary work. No discussion of yellow fever would be complete without the mention of the Army Medical Commission, headed by Surgeon Walter Reed, whose work has helped us so much in the prevention and suppression of this disease. The discovery that

yellow fever is transmitted in nature only through the bite of the *Stegomyia fasciata* has been the stimulus that has led to further work on this disease by men of science throughout the world.

Several commissions, composed of Drs. Salimbeni, Marchoux and Simond, have been sent from the Pasteur Institute, Paris, to Rio de Janeiro to study yellow fever; also, a German commission, consisting of Drs. Neumann and Otto, have made further contributions which have materially advanced our knowledge of the subject.

The Public Health and Marine Hospital Service had another working party in the field last summer during the latter part of the epidemic at New Orleans. Two questions were investigated, viz.: (1) The cause of the disease, and (2) the alleged hereditary transmission of the yellow fever parasite in the mosquito.

We are considerably handicapped in studying yellow fever clinically because of the many instances of mild and atypical cases. Until the cause of the disease is discovered and a certain means of diagnosis is at hand there will be great confusion in the symptomology and diagnosis of this disease.

The subject, therefore, has important practical as well as scientific interest. We spent much of our time in attempting to grow the yellow-fever parasite.[1]

ATTEMPTING TO GROW THE YELLOW-FEVER PARASITE.

In view of the fact that the infective principle causing yellow fever may pass through the close-grained pores of a Pasteur-Chamberland B filter, it seemed to us hopeless, with the limitations of the present microscope, to expect to see the causative agent of this disease by direct examination of the blood.

Novy's work with trypanosomes, both his success in their artificial cultivation and his filtration experiments indicating the possibility of an "ultramisroscopic" phase in their developmental cycle, suggested to us the possibility of cultivating by similar methods the yellow-fever parasite, and thus perhaps of developing a stage in its life cycle which might readily be visible. We attempted, therefore, to grow the parasite of yellow fever in the "water of condensation" of blood-agar tubes.

The culture tubes were prepared in several different ways; both human blood (non-immune) and rabbit's blood were used. Some tubes were prepared with the whole and some with the defibrinated blood. When the whole blood was used it was quickly added while fresh to melted agar, at 42 degrees C., in the proportion of about two parts of blood to one of agar. After mixing, the tubes were slanted and allowed to set. The defibrinated blood was prepared by whipping in the usual way and then added to the melted agar in about the same proportions as before stated. After standing a short time the blood-agar slants thus prepared developed from several drops to about one c. c. of "water of condensation."

A drop or two of blood from typical cases of yellow fever taken from the arm vein during the early stages of the disease was planted into this "water of condensation."

[1]See Bulletin No. 15, Yellow Fever Institute, P. H. and M. H. S.: Report of Working Party No. 3, Yellow Fever Institute: Attempts to Grow the Yellow Fever Parasite: The Hereditary Transmission of the Yellow Fever Parasite in the Mosquito. By M. J. Rosenau and Joseph Goldberger.

Other cultures were prepared with much larger quantities of the yellow-fever blood, using the yellow-fever blood itself as a part of the culture medium. To tubes containing about two c. c. of melted agar about four c. c. of fresh yellow-fever blood were added as quickly as possible after withdrawal from the vein. Other tubes were similarly prepared with the defibrinated yellow-fever blood.

Some of the cultures were kept in the incubator at 37 degrees C., and others at room temperature. Of the latter some were kept in the dark, and others exposed to the light in order to stimulate the conditions as they appear to occur in the mosquito.

The "water of condensation" was examined from time to time, both in hanging drop and in strained smears. It was found to contain large numbers of bodies of various sizes and shapes, some of them exhibiting curious and exaggerated Brownian motion. All of the particles were interpreted as degeneration products, mostly from the cellular elements of the blood.

HEREDITARY TRANSMISSION OF THE YELLOW-FEVER PARASITE IN THE MOSQUITO.

The question of the hereditary transmission of the yellow-fever parasite from the *Stegomyia fasciata* to its progeny is of interest both biologically and practically. Reasoning by analogy, such transmission cannot be regarded as impossible, as it is known to occur in some probably closely allied diseases, as through the tick in Texas fever and canine piroplasmosis. Schaudinn has satisfied himself that hereditary transmission of the tertian malarial parasite (*Palsmodium vivax*) occurs in *Anopheles,* and recently Dutton and Todd have shown that the spirochaete of the tick fever of the Congo is passed from tick to tick through the egg. To the sanitarian the question is of interest in its bearing on the problem of the recrudescence of yellow fever.

The recrudescence of epidemics of yellow fever has heretofore been explained in one of two ways: (1) Either a *Stegomyia fasciata* that had become directly infected by feeding on a case of the disease had survived (as they are experimentally known to be able to do), or (2) the infection had, in the interval between the epidemics, been continued by unrecognized cases, and on the recurrence of favorable conditions the disease would reassume epidemic proportions.

From time to time a third explanation has been advanced, namely, the transmission of the infection from the mother mosquito through the eggs to her progeny, which, under favorable circumstances, were capable, without themselves directly having had access to a case of yellow fever, of giving the disease to a susceptible individual. This explanation has now received the support of an experimental case of yellow fever induced by the sting of a *Stegomyia fasciata* apparently hereditarily infected. This case is reported by Marchoux and Simond in a paper on "The Hereditary Transmission of the Yellow-Fever Virus in the *Stegomyia Fasciata.*" Against this one positive case we obtained negative results in attempted inoculations of 13 non-immunes.

In an endeavor to account for the divergence of our results from those of the French workers we considered several factors in the problem, failure to comply with any of which might readily be productive of negative results. We believe, however, that our work, so far as we can judge from the details in their paper, closely parallels the work of Marchoux and Simond. Naturally, the first factor which arose for consideration was whether the mothers of the *Stegomyia fasciata* used by us for the inoculation of our non-immunes were infected. Marchoux and Simond state that the mother of the insect whose sting produced the positive case of fever had been made to feed on *several* (number not stated) of their cases of yellow fever in order to determine a heavy infection. In our work one of our mother mosquitoes had three feedings of yellow-fever blood from two severe cases during the early stages of the disease. Two other mother mosquitoes had one feeding of yellow-fever blood early in the disease.

That the interval between the infecting feed and oviposition must enter as an important element in the transmission of the infection through the eggs to the progeny—if such transmission ever takes place in yellow fever—must be evident. Marchoux and Simond do not report clearly on this point; they state simply that their mosquito was 20 days old at the time of oviposition, and that some time prior to the ovipositing it had been made to sting several cases of yellow fever.

Another important factor in the problem, and one to which Marchoux and Simond call attention, is the time needed by the hereditarily infected mosquito to become infective. In their case this was 22 days. In our work the inoculations were carried up to and including the 49th day.

A factor in the problem which is of prime importance and which must always be reckoned with in estimating the value of negative results is the susceptibility of the subject used for the inoculation to the disease. We were careful to select only those who we were satisfied never had had the disease.

In view of the negative results recorded by us in our efforts to confirm the positive work of Marchoux and Simond we feel that additional work will be necessary to settle the question of the hereditary transmission of the parasite of yellow fever in the *Stegomyia fasciata*. Nevertheless, the sanitarian will do well to continue his measures of mosquito destruction after the suppression of an epidemic.

TRUTH IS MIGHTY AND HAS PREVAILED.

In our work upon yellow fever last summer at New Orleans it was interesting to note the great difference in the practical work of suppressing this epidemic from similar work in former days. Reed, Carroll and Agramonte had published their epoch-making discovery but five years prior. We know that administration, especially in sanitary matters, lags far behind the sanitary sciences. This conservatism is sometimes proper and usually inevitable. In this instance, therefore, we have no cause for complaint

when we review the magnificent and successful work in suppressing the epidemic of yellow fever at New Orleans last summer.

In the few years which have elapsed we have learned to no longer fear fomites. This point was brought home very strongly to me when I noticed that the soiled laundry from the yellow-fever hospital was daily carried, without any precautions, to an outside laundry. We can well imagine how such a procedure would have been regarded prior to our exact knowledge on this subject.

Another striking instance showing how quickly the public mind had been educated to the true facts concerning the disease came to my attention. In the early part of October yellow fever appeared in virulent form in a small Mississippi town. A family called N'importqui, was the first to be stricken. The mother fell ill with the fever and died in five days. The head of the household, an intelligent man, fearing that the disease would take other members of his family, and not being able to secure proper nursing and medical attention in the small town in which he resided, came with his six children to New Orleans and went directly to the yellow-fever hospital, being convinced, he said, that this well-screened hospital, although full of yellow-fever patients in all stages of the disease, was the safest place in the epidemic area.

I might cite other instances in New Orleans in which patients attacked by yellow fever in boarding-houses were removed. When the mosquitoes in the house were destroyed and the patient screened or removed, the other boarders did not leave, as they had entire confidence in the fact that, although they had been in contact with the sick boarder, they were in no danger from further spread of the disease in view of the measures taken.

COUNTY SOCIETY MEETINGS.

THE Harford County Medical Society held a most interesting meeting on November 29 and one of the best attended recently.

Dr. L. M. Allen of Baltimore read a paper on "The cause and prevention of puerpural sepsis."

Examination for life insurance companies was discussed, and the society voted unanimously to make no examinations for regular companies for less than $5.

THE annual meeting of the Dorchester County Medical Society was held at the house of Dr. John Mace at Cambridge, Md., on December 18, 1906.

Dr. B. W. Goldsborough of Cambridge was elected president, and Dr. W. H. Houston of Fishing Creek, secretary-treasurer, for the ensuing year.

An address was made by Dr. Randolph Winslow of Baltimore on "European observations," and papers were read by Dr. Price of Vienna, Md., on "Medical ethics," and by Dr. B. W. Goldsborough on the "Diagnosis of typhoid fever."

The society was entertained by the local profession at the hotel and by Dr. Mace at his residence.

Dr. Victor Carroll was elected a member, and another application for membership was referred to the censors of the society.

This society is in vigorous condition and is doing an excellent work.

Current Literature.

REVIEW IN PEDIATRICS.

Under the Supervision of José L. Hirsh, M.D., Baltimore.

THE PASSAGE OF ANTIBODIES INTO THE BLOOD OF NURSLINGS. La Torre. *British Medical Journal,* March 10, 1906.

La Torre states that there is general agreement as to the elimination of antibodies by the milk. The only questions are as to whether they find their way in any useful quantity into the blood of nurslings, and if so, whether this happens constantly or only in the case of very young infants. He criticises Salge's experiments in elucidation of these points as being too few in number and of purely scientific rather than of clinical interest. La Torre made his observations on 17 healthy children of ages from one month to two years. To begin with, 22 children were available, but five of these began to suffer from gastro-intestinal disturbances and were left out of account. In five cases 3000 units of Behring's serum were injected into the wet nurse. In each of the other cases 6000 units were employed. This quantity of serum was administered in three injections at intervals of three days. The antitoxic power of the nursling's serum was tested the day before the first injection and again three days after the last injection. In the first series of 10 experiments from one-tenth to one-sixtieth c. cm. of the child's serum was withdrawn and mixed with from one to ten times the minimum lethal dose of diphtheria toxin and injected hypodermically into a guinea-pig. The object of these experiments was to determine whether any useful degree of antitoxic power could be conferred on the blood of nurslings by means of milk. In the second series of seven experiments a smaller dose of toxin was used, and an attempt was made to find in the time of onset of edema and other symptoms a means of measuring the antitoxic power conferred on the child's serum. The author found that the passage of antibodies was on a very small scale. He could only rarely satisfy himself that as much as one one-thousandth part of the antitoxin injected into the wet nurse was present in the blood of the child. He therefore entertains no hope that the child can be immunized by injecting the wet nurse. The passage of antitoxin into the child's serum was not found to depend in any way on the age of the child.

* * *

THE RELATION OF WEIGHT TO THE MEASUREMENTS OF CHILDREN DURING THE FIRST YEAR. E. C. Fleishner. *Archives of Pediatrics,* October, 1906.

The large amount of investigation that has been carried on relative to the weight and measurements of children has had bearing chiefly on normal children. It was with the idea of determining,

if possible, the relation which the weight and measurements of abnomal infants bear to a normal child, what relation, if any, these measurements bear to one another, and especially the extent to which the increase in the measurements of an infant depends upon the increase in weight, or conversely to what degree the weight influences the increase in the measurements, that the line of work with which this article deals was taken up.

Five hundred children were weighed and measured as a basis of the statistics. Of these 25 per cent. were well nourished, 35 per cent. fairly well nourished and 40 per cent. were poorly-nourished children. The babies were all under one year old. The data obtained consisted of the weight, length, circumference of the head in the occipito-frontal diameter, circumference of the chest at the nipple line, and that of the abdomen at the umbilicus.

A series of charts and tables are given, bringing out rather clearly the points discussed, and the following conclusions are drawn:

1. The height and circumference of head, chest and abdomen in normal, well-nourished children increase as the weight, the greatest increase in the measurements occurring during the first quarter of the year, when the greatest gain in the weight takes place; the next greatest increase in the measurements occurs, coincident with the gain in weight, during the second quarter of the year, while the least increase in the measurements takes place in that part of the year when the gain in the weight is the least, the third quarter of the year.

2. The height and the circumference of the head and chest in fairly well-nourished children likewise increases primarily as the weight, although in this class of patients age plays more of a part than in the well nourished. The greatest increase in measurements occurs in the first quarter of the year, with a similar gain in the weight. The increase in the height and circumference of the head is slightly greater in the third quarter than in the second quarter, although the gain in weight during these periods is the same, showing the slight bearing that age, irrespective of weight, has on the growth of the body, while the smallest gain in the weight and the growth is in the last quarter of the year.

3. It is in the poorly-nourished children that age plays its most important part, and the measurements of these children, compared with the well nourished, increase most rapidly in the last part of the year.

4. In the poorly-nourished children, most of whom are probably somewhat premature, when the weight is below normal all the measurements are correspondingly below normal. The height and circumference of the head reach the normal birth measurements a little ahead of the weight, while the chest and abdomen are two months later in reaching the measurements of a normal child at birth.

5. When the weight is stationary the increase in the measure-

ments is very small, depending upon the slight influence which age has upon the growth of the infant, notwithstanding the weight.

6. The measurements of the infants of the same weight, notwithstanding the age, are very similar, the small differences depending, as when the weight of a child is stationary, upon the very slight influence which age has upon growth.

7. The final conclusion can be drawn that during the first year of life the primary factor in the increase of the measurements of the body is a steady, consistent increase in the weight.

* * *

Sodium Citrate in Infant Feeding. A. C. Cotton. *Journal of the American Medical Association,* October 6, 1906.

The writer presents a brief resume of his experience with sodium citrate, with the firm conviction that through its inhibition of dense coagulation of cow's milk in the presence of an acid and rennin it may prove valuable in the solution of the proteid problem. He began its use in cases in which varying milk mixtures had been used with poor success, and later extended its use considerably. He draws his conclusions from a study of 112 cases, embracing nearly all conditions, from simple dyspepsia to marasmus, and ranging in age from the new born to adults who have suffered from milk dyspepsia. Sodium citrate being very soluble in water, the method of employment is simple, as follows: An aqueous solution is ordered containing from one to five grains to the dram. A quantity of this solution is furnished the mother or nurse, with instructions to add to the baby's bottle, immediately before feeding, enough of the solution to represent, one, two or even three grains of the citrate to each ounce of milk in the feeding mixture, according to requirements. The feeding mixture may consist of varying dilutions of milk with water or gruel, with the addition of cane or milk sugar, with or without cream. No alkalies are added, the sodium citrate used being a neutral salt. A most notable feature in this method of feeding is the large proportion of milk in the feeding mixture that the infant will tolerate without evidence of gastric disturbance or the appearance of any considerable amount of undigested casein in the stools. In fact, the stools of babies fed on citrated milk the writer regards as characteristic, being firm, free from odor and homogeneous in color and consistency.

The duration of the administration of the sodium citrate, as well as the quantity employed, varies considerably in different cases, the purpose being to bring the baby's feeding up to whole milk as rapidly as possible. As toleration is established the amount of citrate is reduced gradually until it can be discontinued. The citrate is profitably resumed on the appearance of signs of indigestion.

Some experiments carried on by the writer's assistant are given with the following conclusions:

1. Sodium citrate in .25 per cent. solution retards, and very high percentage inhibit coagulation.

2. The presence of HCl hastens coagulation.

3. Diluting milk generally retards coagulation.

4. Gruels appear to have little or no effect in retarding coagulation more than water when the citrate is used.

5. The coagula of citrated milk are softer, smoother, more flocculent than those of milk not thus treated.

England, in studying this subject from a chemical and physical point of view (*Journal of the American Medical Association*, October 20, 1906), concludes that sodium citrate, which is a neutral salt, has no decomposing action on calcium casein in the cold, but that it does exert an important physical influence on the casein of milk; that when the citrated milk is brought in contact with the gastric juice the sodium citrate is decomposed into sodium chloride, which has important physical, chemical and therapeutic properties in the digestion of the proteids of cow's milk, more important probably than has hitherto been believed. Whether the citric acid formed has any more important therapeutic value than the hydrochloric acid of the gastric juice would seem to be very doubtful.

Society Reports.

THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY.

MEETING HELD NOVEMBER 5, 1906.

Dr. Barker in the chair.

Exhibition of a Case of Cerebral Palsy—Dr. Amberg. Child, a male, 22 months old, with a history of asphyxiation at birth which lasted some time. The child now shows athetoid movements of the hands when excited and a slight amount of the feet also. Otherwise the hands are held flexed at the wrist and show a certain degree of spasticity. The patellar reflexes are increased, and the child, though 22 months of age, cannot stand alone, and is backward in speech. The athetoid movements, together with the increased reflexes and the history of asphyxiation at birth, make the diagnosis of cerebral palsy definite.

Exhibition of Cases—Dr. Cullen. Case 1. Patient, aged — years. When she entered the Church Home on July 29 of this year a diagnosis of cyst was made. There was great enlargement of the abdomen, with much edema of the abdomen, the lower extremities, and the buttocks. She could not lie on account of suffocation. If by accident she got upon her back she had to call for help, as she could not turn from that position by herself. So large was the tumor that it came down almost to her knees. The walls of the abdomen were very thick, and it could not be determined whether the tumor contained fluid or not. On attempting to tap, nothing but blood was obtained. The incision was increased, and it was found that the tumor could not be shelled out. It was adherent to the omentum, and on the

right side a part of the liver was attached to it, and just below the liver the right tube and ovary. There were many large vessels from the omentum, some 6 or 8 mm. in diameter. The incision had to be extended from the xiphoid to the symphisis, and measured just 4 feet in length. The tumor was taken out in entirety. Attached to the extirpated mass was a piece of liver 3 cm. in diameter and the right tube and ovary. Great difficulty was anticipated in handling the tumor at operation, so previously a large foot-tub was sterilized, and, by allowing the lower part of the tumor to rest in the tub, it could be easily moved about by means of the handles. Towards the latter part of the operation the patient showed some signs of collapse. The total time of the administration of the ether was 1 hour and 20 minutes; that of the operation 55 minutes. On the following day the patient was all right. Ten or 12 days later diarrhea developed, but it may be mentioned that many of the other patients were suffering from diarrhea at the same time. Two or three days after operation a bed-sore appeared on the buttocks which could not be prevented on account of the edema. The total weight of the tumor was 89 pounds. The patient on the table weighed 154 pounds, and on leaving the hospital 81½ pounds. Sections of the tumor showed it to be a myoma undergoing hyaline degeneration. It was filled with blood and collapsed on opening. The uterus was very little enlarged, and the tumor, the only one present, was attached by a very small pedicle. The walls of the tumor on the inside were shaggy, and where it lay against the vertebral column were considerably thinned and would undoubtedly have ruptured soon at this point. There was little discomfort, and the temperature was normal up to a few days before operation, when it ran up to 102° or 103°. The recti muscles were so much separated following the operation that they touched the bed on either side of the patient and the skin was very loose and wrinkled. Now, however, the parts have contracted down almost to normal. Dr. H. P. Cole, in going over the literature on large tumors, found Clarence Webster's case to have been the largest one removed. It weighed 87 pounds and was a cystic myoma. Another, Eastman's case, weighed 60 pounds. Therefore this tumor has been the largest successfully removed.

Case 2. This case was of particular interest because of its parasitic character. The omentum was attached at the upper end, some of the vessels being 4 to 5 mm. in diameter. On the under side was a cord of vessels 6 cm. thick. The vessels ran down the under side and plunged into the tumor. The pedicle was only 2 or 3 cm. in diameter.

Case 3. Girl, 21 years old, who was supposed to have been pregnant one year before, but nothing came of it. The tumor was hard and apparently movable. An incision was made in the midline, and the peritoneum was found to be greatly thickened. There was an escape of grumous material; pus foci were seen. The mass was shelled out from above, and turned out to be the uterus. The tubes and ovaries were normal There was a pregnancy of six or seven months, with a dead and macerated fetus in a collection of purulent material. The walls of the uterus were adherent to the abdominal walls, which prevented the escape of pus into the peritoneal cavity.

Case 4. The patient had a large mass in the abdomen reaching to above the umbilicus. A diagnosis of myoma or dermoid cyst was made. The

uterus was normal. On the right side a pus tube was adherent to the tumor. The transverse colon and omentum were also adherent. The sticky material which is usually found in dermoid cysts was encountered. The tumor was removed, and was considered a dermoid cyst, some hair being observed in it. But section later showed the remains of a fetus. The woman gave a history of having been pregnant four years before. She had experienced labor pains, but nothing had been expelled.

Case 5. A case of chorio-epithelioma, with corpus leuteum cysts in both ovaries. The history was not clear. She was supposed to have had an abortion, but no villae were obtained. The breasts, however, showed chlostrum. On opening the abdomen suspicious areas were found. An incision into the uterus showed a mass of spongy material. This then was treated as an infected area and a hysterectomy was performed. It turned out to be the largest and most perfect chorio-epithelioma ever removed.

The Topography of the Parathyroids—Dr. MacCallum. The exact disposition of the parathyroids is of interest especially to surgeons. The glands are distinct from the thyroid gland developing from a distinct rudiment, and their removal gives different symptoms. The symptoms of removal are as follows: In most animals tetany, followed by death, is the result. It is a convulsive disease, due to some poison acting on the central nervous system. It may be cured temporarily by bleeding and giving an infusion, or by giving parathyroid extract either intravenously or extraperitoneally. These symptoms are not produced in the goat, pig, sheep, etc., for the reason that the position of the glands are not known and cannot all be removed. Only two are found in the ox, none whatever in the pig, and in the goat only four. Partial extirpation in dogs, as a rule, gives no tetany. If only one gland be left, certain strain may bring on tetany, as lactation, etc. Tetany in human beings was long thought to be due to removal of the thyroid gland. There are weighty reasons for the surgeons to maintain the integrity of the parathyroids. Dr. MacCallum has prepared a number of charts made from dissections at autopsies showing the various positions the parathyroids may assume. It is easy to distinguish between the parathyroids and the thyroids. The parathyroid is small and not elastic like the thyroid, but soft and mushy. It is not translucent, and is of a chestnut or a yellow ochre color, homogeneous. The glands are about 8 mm. long or shorter, 2 cm. wide, flabby and tonguelike. They are easily dissected out when approached from behind. The thyroid blood supply is derived from the superior and inferior thyroid arteries, and that of the parathyroids from separate and distinct branches of these arteries, which are often quite long. There is a soft, loose areolar tissue covering the thyroid gland and extending back of the trachea. The parathyroids are found in this loose tissue, four in number, in more than half of the cases. The number found depends usually on the carefulness of the search. The most frequent, though not constant, position of the glands is—and for the upper ones—along the posterior border of the thyroid where the superior artery enters it. The lower gland lies in a notch of the thyroid along its posterior border. This is by no means constant. The upper one may lie near the lower one; this may be symmetrical. Or the upper may be lower still and the lower one below the border of the thyroid or attached to the lower pole. In some cases one may be found over the trachea. In one case Dr. Whipple found the thyroid on

one side completely atrophied, and the superior and inferior parathyroid lay quite independent of it, loose, as it were, in the tissue. The parathyroid is nearly always loosely attached and can be picked up on the stalk of the vessel. In the ligation of the thyroid arteries the ligature must be placed inside of the parathyroid branch, which is, of course, more difficult in a tumor of the thyroid. The tetany caused by the removal of the glands, Dr. MacCallum has found, can be warded off or stopped by injection of the parathyroid extract or feeding the glands by mouth. Those of the ox are used, in which animal two are found as brown masses at the top of the thymus on either side.

Book Reviews.

Lectures on Tropical Diseases: Being the Lane Lectures for 1905, delivered at Cooper Medical College, San Francisco, U. S. A., August, 1905, by Sir Patrick Manson. Chicago: W. T. Keener & Co. 1905.

These 10 lectures make a very interesting volume of 230 pages. The tropical diseases were, as Manson says, very appropriately chosen as the subject for the Lane Lectures in 1905. For San Francisco, the great American gateway of tropical travel, the tropical diseases are of extraordinary interest. Quite as appropriate as the choice of a subject was the choice of a lecturer for 1905. The lectures do not cover the list of tropical diseases so fully as the well-known manual by the same author, but the lectures, being necessarily limited in scope, are all the better for the omissions. In his selection of diseases to be considered Manson was guided by the particular needs of those to whom the lectures were addressed. The diseases discussed are ankylostomiasis, the Guinea-worm, the lung-fluke, the Bilharzial parasites, malaria, trypanosomiasis, febrile spleno-megaly. Two lectures are devoted to the diagnosis of tropical diseases, and in these lectures Malta fever, relapsing fever, and leprotic fever are discussed.

The ninth lecture is on the treatment of tropical diseases, including dysentery and spone. These two diseases are not considered in the preceding lectures.

The colloquial style of the lecturer is admirably preserved in the printed volume, and, once opened, the book is not laid aside so easily as the more formal treatise on the same subject.

Surgical Pathology and Treatment of Disease of the Ear. By Clarence John Blake, M.D., Professor of Otology in Harvard University, and Henry Ottridge Reik, M.D., Associate in Ophthalmology and Otology, Johns Hopkins University. New York and London: D. Appleton & Co.

Dr. Blake and Dr. Reik have shown both common sense and discretion in the discussion of their subject-matter. A strong conservatism is especially necessary in discussing surgical procedures in diseases of the ear owing to the strenuous advocacy of operative fads by various surgeons and their followers. The operations selected are generally those which are simplest and have given the best results. Both the anatomy and pathology of the ear are discussed from a strictly surgical standpoint.

The surgery of the ear includes not only special operative otology, but

general surgical technique and general and local anesthesia—points upon which the otologist in general lays insufficient stress.

The text is greatly amplified by a number of excellent plates. These facts and the avoidance of unnecessary details of structure make the book a convenient and safe guide for the operator. The accessory surgery of the ear, such as the removal of adenoids, infusions and intravenous medication in septicemia, and lumbar puncture in meningitis, are desscribed.

The appendix describes the use of various instruments of precision and some special operations, such as that of Bourguet for surgical exploration of the labyrinth. An interesting abstract of the localizing symptoms of brain abscess is furnished by Dr. Waterman of Boston.

Surgical Suggestions. Practical Brevities in Surgical Diagnosis and Treatment. By Walter M. Brickner, M.D., Chief of Surgical Department, Mount Sinai Hospital Dispensary, New York; Editor *American Journal of Surgery,* and Eli Moschcowitz, M.D., Assistant Physician Mount Sinai Hospital Dispensary, New York; Editorial Associate *American Journal of Surgery.* Duodecimo, 60 pages. Cloth, 50 cents. New York: Surgery Publishing Co. 1906.

This little book is most novel, not only on account of the many original terse and epigrammatic practical suggestions given, but its general appearance and attractive form. It contains 250 suggestions grouped under proper headings, and is carefully indexed. While some of the items are familiar to the practical surgeon, they are presented in a manner that will impress them on the reader's memory. The book is bound in heavy cloth, stamped in gold, and the text is printed upon India tint paper, with marginal headings in red. These suggestions were published serially in 1905 in the *American Journal of Surgery.*

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially-Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene, and other topics of interest to Students and Practitioners by Leading Members of the Medical Profession Throughout the World. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia, with the collaboration of William Osler, M.D., Oxford; John H. Musser, M.D., Philadelphia; James Stewart, M.D., Montreal; J. B. Murphy, M.D., Chicago; A. McPhedran, M.D., Toronto; T. M. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; I. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Edmond Landote, M.D., Paris; Richard Kretz, M.D., Vienna, with regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels, and Carlsbad. Volume II. Sixteenth Series. Philadelphia and London: J. B. Lippincott Company. 1906.

The 1906 Series of International Clinics fully sustains the reputation of this admirable quarterly. This volume, the second, contains 25 articles, among which we mention especially one by Delancey Rochester on "The Prognosis and Treatment of Chronic Valvular Disease of the Heart;" one by Philip Zenner on the "Prophylaxis of Nervous Disease, With Special

Reference to Educational Influences in the Growing Child;" one by Frederick T. Lord on "The Diagnosis and Treatment of Abscess and Gangrene of the Lungs, With Special Reference to Operation;" one by William H. Porter on "The True Significance of Uric Acid;" one by Louis Fischer on "Infantile Derangements Due to Improper Breast Feeding, With Suggestions for the Prevention and Treatment of Constitutional Disorders, Such as Rickets and Marasmus;" one by William L. Rodman on "Tumors of the Mammary Gland, With Special Reference to Their Diagnosis, Prognosis, and Treatment;" one by Alberto Rovigli of Bologna on "Experimental Researches Bearing on Surgical Intervention in Nephritis;" one by W. G. B. Harland on "Intratrachial and Intralaryngeal Injections."

Receipt is acknowledged of the following books:

Eating to Live. By John Janvier Black, M.D. Publishers, J. B. Lippincott Company. 1906.

Progressive Medicine. Edited by Hobart A. Hare, M.D. Publishers, Lea Bros. & Co. 1906.

How to Suppress a Malpractice Suit. By Thomas Hall Shastid, A.M., M.D., LL.B. Publishers, Marion Publishing Co. 1906. Price, $1.50.

Materia Medica and Therapeutics. By Edward J. Kiepe, Ph.G., M.D. Publishers, Lea Bros. & Co. 1906. Cloth, $1 net.

Second Report of the Wellcome Research Laboratories at the Gordon Memorial College, Khartoum. By Andrew Balfour, M.D., Director. Publishers, Department of Education, Soudan Government, Khartoum. 1906.

Operative Gynecology. By Howard A. Kelly, A.B., M.D., LL.D., F.R.C.S. (Hon. Edin.). Second edition, revised and enlarged. Publishers, D. Appleton & Co. 1906. Vol. I and Vol. II.

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Diseases of the Digestive System. Edited by Frank Billings, M.D. An authorized translation from "Die Deutsche Klinik" under the general editorial supervision of Julius L. Salinger, M.D. Publishers, D. Appleton & Co. 1906.

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MARYLAND MEDICAL JOURNAL.

JOHN S. FULTON, M.D., *Editor.*

Associate Editors:

THOMAS R. BROWN, M.D. | HUGH H. YOUNG, M.D.
ROBERT REULING, M.D. | JOSE L. HIRSH, M.D.

BALTIMORE, JANUARY, 1907

THE FETICH OF DISINFECTION.

ONE of the most spirited discussions during the Boston meeting of the American Medical Association occurred in the section on Sanitary Science and Hygiene after the reading of Dr. Chapin's paper entitled "The Fetich of Disinfection." Printed in the *Journal of the American Medical Association* for August 25, the discussion looks more important than the paper. Everyone who spoke opposed the views of Dr. Chapin. Few men in America have had as long experience in public hygiene as Dr. Chapin and none has examined the results of his procedures more critically. The title of the paper is rather startling and the argument tends strongly to discredit the whole practice of disinfection as carried out by boards of health. The author is careful to say at the outset that the especial object of his attack is the routine disinfection which the people generally demand and health officers supply after death or recovery from contagious diseases—the terminal disinfection, as the author calls it. The argument is summarized by Chapin as follows:

"1. The pathogenic bacteria tend to die rapidly after discharge from the body.

"2. There is very little bacteriologic evidence that things remain long infected, and therefore contact between the non-infected *persons* and the infected *things* must be very direct and very close in point of time if the *things* are to transmit the infection.

"3. Clinical evidence of the necessity of disinfection is wanting.

"4. The true explanation of the spread of contagion is the great number of unrecognized, atypical, and 'carrier' cases.

"5. Infected *persons,* not infected things, are to be feared.

"6. Disinfection, that is, official disinfection as a final precautionary measure, has little value in preventing the spread of the common contagious diseases.

"7. This sort of disinfection is a powerful factor in preventing sanitary progress by encouraging belief in discredited theories.

"8. While it is by no means advisable to abandon disinfection entirely, it should not be made so important a part of public-health work, and should

not be insisted on unless it is practically certain that no member of the household remains infected, and should be refused when it is probable that any member of the household is so infected."

If one keeps in mind the terminal disinfection, the "expiatory sacrifice," with which we are too familiar, it is possible to follow this argument without putting one's back up, for official disinfections are, in fact, very often little better than incantations, and deserve a scorching blast of scientific criticism. It is impossible, however, to consent to Dr. Chapin's argument; his antithesis between persons and things is so overstrained. When one thinks of soil, water, food, clothing, utensils, domestic animals, household pests, typhoid fever, diphtheria, yellow fever, malaria, tuberculosis, cholera infantum, dysentery, tetanus, anthrax, plague, smallpox, one feels obliged to dispute nearly the whole of his summary. Many pathogenic organisms live long outside the body. There is abundant bacteriologic evidence that *things* remain long infected. Contact of non-infected persons with infected things is often more direct and closer than any sort of personal contact. Clinical evidence of the value of disinfection is abundant. The spread of infection is but partly explained by the great number of unrecognized, atypical, and "carrier" cases. Infected things are to be feared. Official disinfection—terminal disinfection—has considerable value in preventing the spread of many contagious diseases. The routine terminal disinfection is often, as Chapin says, an obstacle to sanitary progress, though not by encouraging belief in discredited theories so much as by discouraging faith in established truth. Finally, disinfection of premises should not be refused when it is probable that an infected person is on the premises, even though it be impossible to include such a person in the disinfection.

In Providence the merits of disinfection are being tested by ceasing to disinfect. The experiment has been going on for a year, and the results appear to be that "return" cases of diphtheria occurred in 1.55 per cent. of instances when disinfection was omitted and in 2.3 per cent. of instances where disinfection has been done. These figures, Chapin thinks, count against disinfection. Since these ratios are based on but 345 house outbreaks, they should be discredited on account of paucity of data. But if the number of outbreaks had been 345,000 the recourse to figures would have been even more unfortunate, since a terminal disinfection cannot be worse than useless, and an explanation of the numerical paradox would necessarily be sought in some other part of the prophylaxis.

It is not only possible, but easy to improve the bedside prophylaxis of diphtheria to a higher efficiency than that of a public health department, but not to such efficiency that the terminal disinfection might be safely omitted. If, from the onset to the end of the attack, the avenues of exit have been guarded and the infectious material destroyed as it issues from the body, the small task remaining might possibly be as well done by a good housekeeper as by a good fumigator. But in practice bedside prophylaxis can almost never begin at the beginning, and very rarely continue without error to the end; so that something will always remain for the official disinfector to do, and this terminal task will usually be so vaguely defined that it must be accomplished by blunderbus methods.

It must be admitted, however, that much official disinfection, particularly

the terminal disinfection after common contagious diseases, is wretchedly unscientific, and ought to be shown up for what it is, a trivial ceremony, very little, if at all, more efficacious than the Mosaic rites of purification. If one were forced to choose between the kind of "ridding up" which satisfies a first-rate housewife and the perfunctory liberation of formaldehyde gas which satisfies many health officers, the plain housecleaning would be a wise man's choice; but between a slovenly housecleaning and slovenly fumigation advantage lies in the fumigation. If Chapin meant to attack the too prevalent slovenliness of public disinfection, this is a fair mark, which he should have hit and hit hard.

DR. HURD'S VACATION.

THERE is plenty of room in the world for a certain kind of gossip—the ancient and honorable kind which long ago started the word gossip on its strange career. The two young men who married Laelius' daughters were happy in their choice of a father-in-law, for Laelius loved nothing better than to talk about his distinguished friends, and his sons-in-law were not only joyful instigators of such gossip, but also profited largely by it. Indeed the heart of Cicero's great essay on Friendship is in the bosom of Caius Laelius, the consul, who, loving Scipio Africanus like a brother, found little scope for grief in the death of Scipio, his license to praise having been so amplified when Scipio was not only absent, but beyond recall.

Excellent occasions for profitable gossip are often presented when a good man turns his back, for a time, upon his work and his friends in search of rest and recreation. One of the best ways to measure a man is to put him out of sight and earshot, and then examine the place where he was. Dr. Henry M. Hurd has been disposed of in this fashion, and friendly tongues began to wag as soon as his back was turned. He is to be absent for a year, and within a month of his departure the account of his manifold activities seems most surprising. Not that his work has been less well known than it should be, but that it has not been fully appraised. His large work in the organization of Johns Hopkins Hospital, his success in teaching, the editorship of the *Hospital Bulletin,* of the *American Journal of Insanity* and of the Hospital Reports have all given him wide influence. But his absence was required in order that the amount and quality of his work might come fairly into view. One wonders that he was not wholly spent in 16 years of such service. But it appears that Dr. Hurd was not completely absorbed in his largely self-imposed duties. Interesting stories are told to show that he has habitually watched the young men about him and seized many opportunities to lift promising men toward their reasonable ambitions. When he returns, Dr. Hurd will find that a year's vacation has brought him, besides the benefits of rest and travel, the pleasant surprise of having been measured in absentia, by taking the dimensions of the space which he vacated.

Medical Items.

BALTIMORE.

Dr. Henry M. Hurd left Baltimore on November 17 and will spend two months at least in Cuba and Mexico and California. In February he will sail with his family for an extended European tour.

The Hospital for Crippled and Deformed Children netted $1500 as the proceeds of a recent vaudeville entertainment at the Maryland Theater.

The Southern Medical College Association met in Baltimore on December 10. The president, Dr. Christopher Tompkins of Richmond, Va., was re-elected for the coming year.

Prof. H. S. Frenkel of Switzerland addressed the Section on Neurology and Psychiatry of the Medical and Chirurgical Faculty on December 5. His subject was "The Treatment of Locomotor Ataxia by Systematic Exercise."

The Medical Examining Board has lodged information with the State's Attorney for Baltimore city against 13 illegal practitioners. The grand jury has found true bills against 11 of the number, and the other two have left the State.

The Baltimore City Water Engineer has made another of his exhaustive investigations of typhoid fever in Baltimore. He concludes with the continuous conclusion that the Baltimore city water supply does not cause typhoid fever.

Dr. William Osler, regius professor of medicine in Oxford University, made a brief visit in Baltimore recently. On December 10 Dr. and Mrs. Henry Cushing gave a reception in honor of Dr. and Mrs. Osler. From Baltimore Dr. Osler went to Canada to spend the holidays with his aged mother. He will visit Baltimore again before returning to England.

Mr. William A. Marburg and Mr. Francis M. Jencks have presented to the library of Johns Hopkins Medical School two valuable collections of books, together numbering 1800 volumes. One of them is the old Warrington Dispensary collection of Liverpool, England; the other is the Friederich Ahlfeld Library of Marburg, Germany.

Dr. Samuel T. Darling, formerly pathologist to the Baltimore City Hospital, now pathologist to the Isthmian Canal Commission, was in Baltimore on December 9, and on December 12 sailed for Europe. During his two years' service at the Isthmus Dr. Darling has been able to demonstrate a new pathogenic organism, the *Histoplasina capsulata*, which causes an obscure disease characterized by progress in emaciation, anemia and enlarged spleen.

In the December Journal we printed an item about some alleged legislation pending in Congress providing for the placarding of houses in the District of Columbia on account of tuberculosis. Some satirical remarks were made in this proposition. The source of our information concerning this legislation was the news columns of one of the best-known medical weeklies. It seems, however, that no such legislation has ever been proposed in the District of Columbia, and our comments were, therefore, misapplied. We are very glad to announce that the District presents no such phase of anti-tuberculosis legislation, and hope we have not furnished any aid or comfort to those who oppose the legislation really needed and now being sought by the District authorities.

Dr. Isaac Edmondson Atkinson died at his home, 609 Cathedral street, Baltimore, on November 24, after a brief illness of pneumonia. This removes the most distinguished general practitioner of his day in Maryland. Dr. Atkinson was born in Baltimore on January 23, 1846. His father was James Edmondson Atkinson of Easton, Talbot county, and later a prominent merchant in Baltimore. He graduated in medicine at the University of Maryland in 1865, being at that time under 20 years of age. He was a vaccine physician in 1873, and in 1883 during the great epidemic of smallpox he was made superintendent of vaccination. It is not generally remembered, and perhaps was not widely known at the time, that this office was brought into existence by the epidemic of smallpox. Indeed the office was created by the then Mayor, William Pinkney Whyte, now United States Senator, for the purpose of engaging Dr. Atkinson against the pestilence, which had for two years baffled the city Health Department. When the epidemic was subdued, Dr. Atkinson retired from the service of the city, and the office which he vacated was abandoned. For several years before that time Dr. Atkinson had been particularly interested in dermatology, and had been professor of that subject in the University of Maryland School of Medicine. He was, moreover, a remarkable clinician, and in 1881 began to give clinics in internal medicine at the University Hospital. The writer was

present at the first ward clinic ever given by Dr. Atkinson. From 1886 to 1900 he was professor of materia medica, and from 1890 to 1893 dean of the Medical School. He retired from the University in 1900, becoming professor emeritus. He was a consulting physician to Johns Hopkins Hospital from the time of its foundation until his death. Dr. Atkinson was always prominent and active in the affairs of the Medical and Chirurgical Faculty, having held many of the offices, including the presidency, vice-presidency and trusteeship. He was a leader in the movement which gave the Faculty its present fine library. He was president of the American Dermatological Society in 1888. He was the author of many important contributions to medical literature, though his activity in this line was much diminished in recent years. Dr. Atkinson was a remarkably effective lecturer and an inspiring teacher. It seems a pity that the demands of a great private practice should have deprived him of the great record he might have made as a teacher and writer.

MARYLAND.

Smallpox has appeared during December in Frederick and Kent counties.

The Board of Managers of the Maryland State Tuberculosis Hospital is examining sites for the proposed sanatorium. On December 27 Governor Warfield, with other members of the board, inspected sites on South Mountain, Washington county.

To the Medical Profession of Maryland:

The medical profession of San Francisco lost its medical library, the San Francisco County Medical Society Library, in the fire last spring. Most of the psysicians also lost whatever private libraries they had succeeded in collecting. A committee (named below) has been appointed by the American Medical Association and by the Association of American Physicians to collect and send books to San Francisco, both for the library and for private individuals when duplicate copies are sent on, as they are sure to be. Will you send to Dr. W. S. Thayer, 406 Cathedral street, Baltimore, Md., any medical books of value or bound volumes of journals which you can spare. Fairly recent editions of standard text-books, foreign text-books or bound journals (French, German and Italian), hospital reports, monographs of all sorts, books on special subjects, old classics (*e. g.*, Trousseau, Charcot) and the Sydenham Society publications are especially desired. Acknowledgment of all that is received will be made through the medical journals and the books will be packed and shipped as promptly as possible.

Signed: Charles L. Dana, chairman, New York city; Frank Billings, Chicago; E. Bates Block, Atlanta; J. A. Capps, Chicago; T. D. Coleman, Augusta, Ga.; George W. Crile, Cleveland; W. E. Fischel, St. Louis; F. Forchheimer, Cincinnati; Charles L. Greene, St. Paul; Arthur T. Holbrook, Milwaukee; George M. Kober, Washington; Lawrence Litchfield, Pittsburg; Rudolph Matas, New Orleans; H. C. Moffitt, San Francisco; John H. Musser, Philadelphia; William Osler, Oxford, England; Henry Sewall, Denver; C. G. Stockton, Buffalo; W. S. Thayer, Baltimore; R. C. Cabot, Boston, secretary.

GENERAL.

The American Association for the Advancement of Science opened its annual meeting at Columbia University, New York, on December 27. The president of the association is Dr. William H. Welch.

At a meeting of the trustees of the Carnegie Institution in Washington on December 11, Drs. William H. Welch of Baltimore, S. Weir Mitchell of Philadelphia and John S. Billings of New York were re-elected trustees.

Dr. Joseph W. Hearn, clinical professor of surgery in Jefferson Medical College, is very ill as the result of a fall from his carriage on December 4. He was thrown to the pavement and sustained a fracture of the skull. He was unconscious for 24 hours, but at last accounts his recovery seemed possible.

The studies of cholera in Manila have been checked by the death of 10 out of 25 prisoners in Bilibid jail, who were inoculated with anti-cholera serum. The Governor-General has appointed a special commission to investigate these deaths and has suspended the permission to make anti-cholera inoculations.

Dr. Alonzo Garcelon of Lewiston, Maine, died recently at the age of 93 years. Dr. Garcelon has been said (and with reason) to have been known to more members of the medical profession than any other physician of these days. He was quite regular in his attendance at the meetings of the American Medical Association, where his venerable though striking appearance always attracted attention. He was an ex-president of the association, and had also been Governor of his State.

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A STUDY OF HOUSE DISINFECTION AND REINFECTION.

By William Royal Stokes, M.D., and Wilbur P. Stubbs, M.D.,
Baltimore.

THE following communication is intended to show the results obtained by the use of formaldehyde gas in room disinfection after communicable diseases and to demonstrate the effect of this gas upon test cultures. The reinfection of houses following disinfection is also considered. Although disinfection alone is not depended upon to prevent the spread of the communicable diseases, yet we believe that in combination with other means it is useful in limiting their spread. Before stating our results, the methods of prevention in vogue other than disinfection will be mentioned. In order to make a succinct statement the various diseases will be considered seriatim.

Tuberculosis.—A State law of Maryland now requires that every case of tuberculosis shall be reported to the State Board of Health, and when this is done the physician receives a bottle of carbolic acid, sputum cups, Japanese napkins, two waterproof pockets, and a book of directions concerning prophylaxis and cure. In this way the physician becomes the intermediary between the State Board of Health and the patient, and thousands of cases are reached in this way that would otherwise be neglected. The physician is paid a small fee for this service. All tuberculous houses must be disinfected after the removal or death of the patient.

Diphtheria.—One of the most valuable adjuncts to disinfection in preventing the spread of diphtheria is the compulsory reporting of cases and placarding of houses. Although not always effectual, yet the warning card puts most people on their guard and diminishes the exposure to disease or to healthy persons harboring the bacilli in their throats. Every teacher in each public and parochial school receives a semiweekly list of all cases of diphtheria

reported, and no children from the infected house can attend school until after the disinfection of the house and the removal of the card from the door by the health officer. This card is not removed until the throat inspector has visited the house and taken cultures from all of the persons living therein, with the exception of the breadwinner. The throat inspector is especially enjoined to take cultures from both nose and throat of the patient and from the throat of the nurse or mother and of each child in the household. If any of these cultures are positive, the throat inspector visits the house every other day and takes cultures until the throats which contatined the diphtheria bacilli are found to be free from these germs.

It may be urged that this custom is not practicable, since it may keep the placard on the house for weeks. Even if such is the case this entails no very serious consequences. The breadwinners, unless harboring diphtheria bacilli, are allowed free egress and ingress, and the children, deprived of school attendance, no longer serve as sources of general infection to the community.

Occasionally we find that the diphtheria bacillus remains in the throat for several weeks or more after discovery or after convalescence. In a series of about 25 such cases we have found that these can be cleared up by the local application of antitoxin. This method was first proposed to us by Dr. C. Hampson Jones, Assistant Health Commissioner of Baltimore, Md. One thousand units of antitoxin are insufflated through each nostril, and the fluid is allowed to remain in contact with the posterior nares and fauces as long as possible before swallowing. In most of the cases thus treated the diphtheria bacilli have disappeared from the throat in from one to three days, although a small percentage of cases have still remained positive after this treatment. We have found that this method of throat inspection can be carried out in a city of over half a million inhabitants. Even if a few positive cultures follow the first negative culture, a system based upon this method is better than desuetude.

After all of the cultures are pronounced negative the infected room is disinfected by formaldehyde and the card is removed from the door. Permits are left at the house allowing the children to return to school, and the house is relieved of this mild form of quarantine.

The table which follows will show the results of disinfection for five years, and while all rooms were not rendered absolutely sterile as far as surface disinfection is concerned, yet the table shows that the majority of rooms were thoroughly disinfected. As far as the eruptive fevers are concerned, it must simply be assumed that the unknown causes of these diseases were destroyed. The percentage of reinfections from scarlet fever and diphtheria were about the same, and we cannot help but feel that disinfection may have helped to limit the spread of the various eruptive fevers. Steam disinfection of mattresses, pillows and

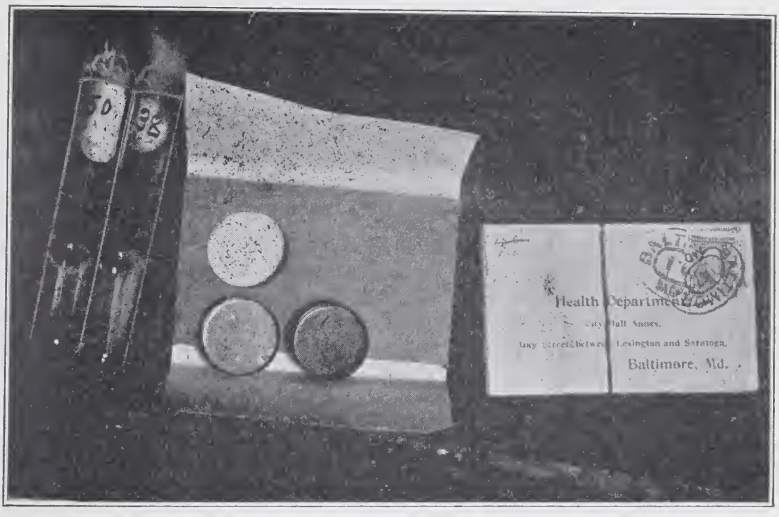
other bulky materials is a necessary adjunct to this surface disinfection.

Results of Disinfections Tested by Control Cultures.

	1901.	1902.	1903.	1904.	1905.
Positive (growth)	288	224	336	438	284
Negative (no growth)	832	1018	1733	1606	1508
Empty, broken or not returned	345	136	302	323	185

These figures show that many rooms in Baltimore receive a surface disinfection controlled by a test culture, and that such a method can be greatly improved if the interest of the householders can be further aroused.

The Eruptive Fevers.—In our city all cases of smallpox are removed to the Quarantine Hospital and the house is disinfected by formaldehyde. Cases of scarlet fever are placarded, and such



cases, as well as measles, are reported to the Health Department and by this department to the schools.

After three weeks from convalescence, if desquamation has ceased, the scarlet-fever sign is removed and the houses are then disinfected.

Method of Disinfection and Control.—Formaldehyde gas is used for the surface disinfection of rooms, and the method is controlled by means of cultures prepared in the following way: It has been the custom to test each disinfection by placing a dry culture of the Staphylococcus pyogenes albus on linen in the room. These linen slips are put into small, sterile tin boxes which are placed in mailing cases, consisting of a perforated light board, in which the tin box can be placed. The tin box is opened just before the fumigation and closed and placed in the mailing case as soon

as possible after opening up the room. The mailing case is left at the house, so that the householder can return the test culture by mail. The generators usually run 30 minutes for every thousand cubic feet of air space in the room. The test cultures, when returned to the laboratory by mail, are removed by sterile forceps and at once placed in Dunham's solution. If the medium is not cloudy in 24 hours it is assumed that the culture was destroyed. If cloudy, a microscopic examination will show the coccus if still present. The accompanying photograph shows the mailing case, the linen slip and clear and cloudy peptone solution in tubes.

Reinfections.—The question of reinfections, *i. e.,* second cases of any contagious disease ocurring in the same house after a proper disinfection following the primary case, has of late assumed some importance among the various boards of health and has given rise to some discussion.

The first question that suggests itself is, what connection may there be between such primary cases and the reinfection? Was the primary case absolutely and entirely responsible for the second case occurring, say two weeks or a month after the recovery of the primary case? Were all reasonable precautions against a reinfection used? Was the patient isolated? Was disinfection done, and, if so, was it thorough and efficient? At this point we wish to take exception to the views of those who hold that disinfection is a relic of superstition and of no importance in the control of communicable diseases. It is important. We do not mean that a communicable disease (as diphtheria, for instance) may be handled in a careless manner during the patient's illness and that disinfection alone will atone for negligence and remove all danger of further contagion. We do say, however, that if precautions are observed during the entire illness a proper disinfection is not only of some use, but is at this time the most effective agent we have at commad to limit the spread of communicable disease.

There appears an article in the *Journal of the American Medical Association* of August 25, 1906, entitled "The Fetich of Disinfection," in which the author reaches the conclusion that "disinfection should not be made so important a part of public health work, and should not be insisted on unless it is practically certain that no member of the household remains infected, and should be refused when it is probable that any member of the household is so affected."

Again he says: "Pathogenic bacteria tend to die rapidly after discharge from the body." In answer, we would like to quote Dr. Osler, who reports a case where virulent diphtheria bacilli were found on a child's toys five months after an attack of diphtheria. Experimentally, diphtheria bacilli have been kept alive on a piece of silk thread for 172 days. We do not think the fault lies so much with the disinfection as with an inadequate quarantine. Unless we disinfect thoroughly we cannot expect good results. In diphtheria, for instance, bits of membrane may be coughed up, deposited on nurse's clothing, and unless she confines herself strictly to the infected room, this infected material may be accidentally wiped off on furniture in another part of the house.

Again, we have seen many convalescent patients, whose throats were charged with virulent diphtheria bacilli, allowed the liberty of the house, distributing diphtheria bacilli from cellar to garret. Should we be surprised at another case developing, and should we lay the blame upon the disinfection? Where the contagion is confined absolutely to one room we may expect good results from proper disinfection. We know, experimentally, that formaldehyde will kill the diphtheria bacillus. If we as health officials refuse, or, as family physicians, reject disinfection for the reason that we cannot disinfect in an *ideal* manner, we are making a grievous error. If the ideal goal is unattainable there is all the more reason to do our very best.

We have collected statistics from 5546 cases of diphtheria and scarlet fever.

In 2807 cases of diphtheria, in Baltimore city, followed by formaldehyde disinfection after the throats of all of the household were declared free from diphtheria bacilli, there occurred during the same year 65 reinfections, or 2.35 per cent.

In 2739 cases of scarlet fever, followed by formaldehyde disinfections (not less than 21 days after official report of the case to the Baltimore City Health Department) there were 69 reinfections, or 2.55 per cent.

In 1769 of the above diphtheria disinfections, there were 40 reinfections where we have obtained the result of the control cultures. Three of these were positive, showing the disinfection for some reason (construction of room, etc.) was technically defective. Thirty-one were negative, showing a thorough disinfection, and six were either missing, sent back empty or were broken in transit.

In 1721 of the above scarlet-fever disinfections, there were 47 reinfections, of which we have obtained the result of the control cultures. Seven were positive, 32 were negative and eight were missing or empty.

We will next show in a series of cases the lapse of time between the fumigation of the primary case and the report of the second case, *i. e.*, date of reinfection. In 1850 of the above diphtheria cases from which we have been able to gather this information, there occurred 47 reinfections (2.54 per cent.).

The following table shows the lapse of time between the disinfection of the primary case and the reinfection:

8	reinfections occurred within	1 week.
13	" " "	2 weeks.
6	" " "	3 "
5	" " "	1 month.
3	" " "	2 months.
5	" " "	3 "
4	" " "	4 "
1	reinfection " "	5 "
1	" " "	6 "
1		
47	total number of reinfections in 1850 diphtheria disinfections.	

In 1571 cases of scarlet fever there were 35 reinfections, or 2.23 per cent.

14	reinfections	occurred	within	1 week.
11	"	"	"	2 weeks.
1	reinfection	"	"	3 "
4	reinfections	"	"	1 month.
3	"	"	"	2 months.
1	reinfection	"	"	3 "
1	"	"	"	4 "

35 total number of reinfections in 1571 scarlet-fever disinfections.

Just what relation exists between the primary and secondary cases in these tables is a question that could be discussed at some length. We have not the time to enter into it here. At best, it would be only a matter of surmise. We will say, however, that the difference in time between the diphtheria and scarlet-fever reinfections is about what we would expect when we take into consideration the clinical characteristics of the two diseases. The period of incubation is, as a rule, longer in scarlet fever than in diphtheria, and, what is more important, the period of infection is more prolonged in scarlet fever than in diphtheria. In a scarlet-fever case, complicated with an otitis, rhinitis, suppurating glands, etc., who can say just how long the infective period may last? In the 25 reinfections occurring within two weeks after disinfection of the primary case, we would have just ground for supposing that the patient was exposed to the same source of contagion as was the primary case, or that the secondary infection was directly due to the primary case prior to disinfection.

In the article quoted above ("Fetich of Disinfection"), the author states that he has been so impressed with the futility of disinfection that, as chief health officer of his city, he has refused disinfection following diphtheria unless certain conditions are met by the patient, which he admits very rarely happens. He cites 258 cases of diphtheria which were not followed by disinfection. In these cases there was 1.55 per cent. reinfection in *two months.* This average for the whole year would, at the same ratio of reinfection, mean 9.30 per cent. reinfections in these 258 cases for the year. Against these figures we have 2807 cases, each followed by a thorough disinfection, with 2.35 per cent. reinfections for the entire year. We recognize that this in all probability is not a fair way to average the reinfections, as certainly a larger proportion of reinfections would occur in the first two months than in any subsequent two months, and that the proportion of reinfections per month would probably decrease in reverse ratio to the length of time after the primary disinfection. All this being true, 2.35 per cent. reinfections for the period of 12 months would seem, eminently, better results than 1.55 per cent. reinfections in 60 days.

Throat Inspection.—We believe in the efficacy of throat inspection in all cases of diphtheria prior to disinfection. Frequently

we have found the inmates of an infected (diphtheria) house harboring virulent diphtheria bacilli in their throats without showing any clinical symptoms whatever. The laboratory is absolutely the only place where such foci of infection can be recognized. These "carrier cases" may at any moment break out into malignant cases of diphtheria, or, worse yet, may contaminate some of those with whom they come into daily contact, and who, for some reason, enjoy less natural resistance to this particular disease. The following table shows the number of throat cultures taken in Baltimore city during the past four years. These cultures were taken after all clinical symptoms had subsided and after the attending physician declared his belief that all danger of contagion had passed and that the premises were ready for fumigation:

Year.	1902.	1903.	1904.	1905.
Number of cultures taken.....	1915	4649	4703	3601
" " negative..	1808	4278	4310	3437
" " positive...	97	371	93	164

When we take into consideration that among the positive cultures enumerated above, not one was taken for diagnostic purposes, but all were taken from throats supposed to be free from infection, it is absurd to expect any other than injurious results if these several hundred nests of infection were allowed to roam at will among the inhabitants of a thickly-populated city.

For the sake of illustrating the importance of throat inspection, and, incidentally, what one infected throat can probably do, one history will suffice. There is in Baltimore a society called the Fresh Air Society, which sends children to the country for a few weeks in the summer. In September, 1903, there was located, some few miles from Baltimore city, a camp of 51 of these children. One child complained of a sore throat, and several later developed clinical diphtheria. One of the writers was sent to the camp, and after making throat cultures of the 51 children, found seven of them containing living diphtheria bacilli. This camp was situated a mile or so from any town or village, and it was somewhat difficult to trace the source of the contagion. We discovered that the man who supplied the camp with milk had a case of diphtheria in his own family a few weeks earlier. We took a culture from his throat and found almost a pure culture of the diphtheria bacilli. That he was responsible for the slight epidemic at the camp would be impossible to prove, but circumstantial evidence seemed to indicate that such was the case.

Prior to July, 1898, the Baltimore City Health Department did not practice routine throat inspection. The following table shows the decrease in the number of diphtheria cases reported since 1898:

Year.	1898.	1899.	1900.	1901.	1902.	1903.	1904.	1905.
Number of diphtheria cases...	2019	1783	1858	1149	941	1436	1241	941

When we take into consideration the increase in population from

541,000 in 1898 to over 600,000 in 1906, it makes the above figures more striking.

It may be urged that the decrease in the number of cases of diphtheria was due to a gradual weeding out of the most susceptible, and, on examining the cases reported previous to 1898, such might seem to be the case, since the number of cases reported yearly is frequently smaller than those reported during the years cited in our statistics. The general stirring up of the profession by placarding houses, more thorough disinfection and a general campaign against diphtheria increased greatly the number of cases reported, and since 1898 we believe that the vast majority of cases have been reported.

The continued restraint of diphtheria during the years succeeding 1898 suggests that this decrease was partly caused by the methods described above, but it will require further study to prove this fact.

In conclusion, we hope to have shown (1) the necessity of a thorough disinfection, (2) that disinfection properly carried out and at the proper time is one of our most effective agents in checking the spread of contagious diseases, (3) the number of reinfections following a thorough disinfection is comparatively small, (4) the importance of throat inspection prior to disinfection in diphtheria.

Current Literature.

REVIEW IN MEDICINE.

Under the Supervision of Thomas R. Brown, M.D., Baltimore.

EXOPHTHALMIC GOITRE.

There are three very interesting articles on the subject of exophthalmic goitre in the *Journal of the American Medical Association,* September 1, 1906.

The first, by Rogers, is on "The Treatment of Thyroidism by a Specific Serum." He, in the first place, classifies the cases as follows:

1. Simple, chronic exophthalmic goitre or thryroidism of moderate severity, with all the symptoms which gave origin to the name.

2. Atypical thyroidism, which includes many of the early cases and those with more or less irregular symptoms, such as absence of goitre or of exophthalmos or of both, or those which complain chiefly of gastro-intestinal disturbance with pain.

3. The chronic toxic cases of thyroidism or severe forms of the disease with slight fever, which may be the terminal stage of the common atypical form or show little or no exophthalmos or goitre from the outset.

4. The acute toxic thyroidism, presenting a clinical picture which Dr. W. G. Thompson has aptly compared to that of malig-

nant endocarditis. These patients show little or no exophthalmos and a small, soft thyroid, and suffer from fever, which may be quite high.

5. The psychopathic or neuropathic cases of thyroidism, which are a comparatively rare, but, from a therapeutic standpoint at least, an important group. They give symptoms which sooner or later indicate organic change in the central nervous system, and are only relievable in the early stages of the disease.

Rogers goes at some length into the symptoms of each of these groups in turn, calling especial attention to the acute toxic cases and the psycho and neuropathic forms. He gives in some detail the history of the specific serum which Beebe has made for the treatment of these cases, this serum being made by separating the nucleoproteids and thyroglobulin from the human thyroid gland, and injecting these bodies into the peritoneal cavity of rabbits, dogs or sheep. As to the results of treatment in the cases, Rogers states that out of 90 cases, which have been followed, 23 have been cured of all symptoms of thyroidism, 52 have been more or less improved, 11 have failed to improve and 4 have died. Of these 90 cases 54 were personally treated or supervised by Rogers himself, and of these 15 were cured and 29 improved.

As regards prognosis, the most important factors to be considered are the kind of thyroid possessed by the patient and the duration of the disease and its clinical type. Histologically, Rogers recognizes four fairly distinct types of gland—one showing increased vascularity, another simple hypertrophy with increase of colloid, a third great increase of epithelium, while the fourth shows a marked anatomic change with loss of the greater part of the thyroid structure, this last representing the terminal stages of a chronic thyroidism and being probably hopeless from a therapeutic standpoint. According to Rogers, patients who have soft thyroids respond more easily to the serum than the patients with hard glands, and, as a general rule, the smaller the organ the better the prognosis. Rogers believes that chance of success with the serum in the case of large hard glands with irregular nodular surfaces is very slight.

As to the type of disease, the acute toxic cases with fever seem to do the best with the least serum, and in these cases there seems to be little difference whether normal or pathologic serum be used, while all the chronic forms of the disease respond better to the pathologic than they do to the normal serum. Of worst prognosis are the chronic toxic types with severe symptoms both of thyroidism and the secondary lesions, dependent on disturbed circulation, and the prognosis is also poor in the atypical chronic cases and most of the psychopathic and neuropathic cases. Rogers describes at considerable length the reaction of the injections and the technique of their administration.

The second article on this most important subject is from the pen of Beebe, who was the first to prepare therapeutic serum for exophthalmic goitre along the lines spoken of in Rogers' paper.

His original article, which was published in the *Journal of the American Medical Association,* February 17, 1906, was more or less in the nature of a preliminary communication, and in the present article he devotes his entire time to a discussion of the improved method of preparing the serum, of its properties, and its therapeutic effects. His experiments have demonstrated that absolute specificity cannot be obtained by this method. It is not necessary to go into details here, but it will be well to call attention to the fact that Beebe insists that both the nucleoproteids and globulin must be obtained for injection into animals. In some cases he has made use of diseased glands, in other cases of normal glands. The animals used for developing the serum have been rabbits, dogs and sheep, and injections have been made into the peritoneal cavity. As a means of standardization Beebe has made use of the agglutinin and precipitin reactions, as it has been found, generally speaking, that the more active the agglutinating powers the more marked the local and general reaction following the injection. Beebe's recent work has demonstrated that it is possible to develop a serum of high therapeutic efficiency from proteids of the normal glands, these results being, of course, in accord with the results of chemical investigation, although his most active serum has come from the proteids of diseased glands removed at operation. Beebe's conclusions are as follows:

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"When all the conditions are considered I believe it is fair to conclude that the serum is an agent of considerable value in the medical treatment of exophthalmic goitre. It has been used in all manner of cases in which it was possible to make a diagnosis and in some cases in which the diagnosis was doubtful. Only a comparatively small percentage of these have been of recent development. A small percentage of trials has resulted in failure, a much larger number in improvement, while an encouraging number of individuals have been completely cured. In making up the statistics which are given here all the cases of which we have any record have been included. These have covered an area from Maine to California, and in many instances the physician in charge of the case has had no other experience with the disease but the one case immediately under treatment. A number of the patients have begun treatment so recently that it is not possible to make any safe conclusion as to the outcome. The number of instances of cure and improvement is so large that they cannot be ascribed to coincidence, and under favorable conditions I believe much can be accomplished by careful serumtherapy."

The third article on this subject is by Shepherd, and is devoted to the surgical treatment of exophthalmic goitre. He first reviews briefly the work that has already been done along this line, calling attention to the fact that Kocher advocates the removal of three-fourths or more of the gland and the ligation of three arteries, while Curtis, although still advocating sympathectomy, has of late been practicing thyroidectomy as well. Shepherd is of the opinion that early operations are the safest, and that the class of cases most

likely to be benefited are not the most severe ones, but those in which the gland is more enlarged on one side than another, in which the gland is excessively vascular, and in which the enlargement has preceded the symptoms of Grave's disease by months and perhaps years, and also in those early cases of enlarged thyroid with a mild form of Grave's disease, in which the gland is soft, vascular and evenly enlarged throughout. The cases in which operation should be avoided are those of large vascular thyroids, in which there are definite febrile exacerbations and excessive tachycardia with the other marked symptoms of toxemia due to thyroidism. Shepherd opposes the view of the majority of physicians who consider that the operation should only be performed in exceptional cases because of its danger. As to results, Kocher's figures are of most value. Of 167 cases operated on, there were 72 per cent. of cures and only 9 deaths. Shepherd himself has always made use of general anesthesia, although other surgeons have found it to be more dangerous than local anesthesia.

He reports 17 cases operated on, with the following results: Three deaths of entirely desperate cases, 9 patients completely cured, 3 much improved, 1 relapse, and 1 lost sight of. Of these 17 cases, 4 were of the cystico-colloid variety, 11 colloid adenoma, and 2 pure hyperplasia without as much colloid as in the normal gland. Sixteen of the patients were females, in 13 exophthalmos was well marked, and in all cases operation was demanded by the patient for the relief of distressing symptoms, and in no case was the operation insisted upon. The conclusion of Shepherd's article is taken up with a brief history of each of the cases separately.

* * *

CLINICAL AND EXPERIMENTAL OBSERVATIONS UPON CHEYNE-STOKES RESPIRATIONS.

Eyster (*Journal of Experimental Medicine,* Vol. VIII, No. 5, October 12, 1906) furnishes an article of real value on the subject of Cheyne-Stokes respiration. He goes carefully into the discussion of the history and the methods of studying this peculiar form of respiration, and then gives in detail the result of a series of experiments. The conclusions of this most valuable article are as follows:

(1) In 10 cases of Cheyne-Stokes respiration observed clinically the alternate periods of respiratory activity and apnea were associated with Traube-Hering waves of blood pressure. These cases may be separated into two groups characterized by the relation of the respiratory changes to the changes of blood pressure. In one group the period of respiratory activity was associated with a rise of blood pressure, the period of apnea with a fall; in the other group the reverse relations existed. The former group included two cases of Cheyne-Stokes respiration occurring with increased intracranial tension. The latter contained eight cases with cardiac and arterial disease.

(2) By means of cerebral compression periodic respirations

may be produced experimentally, and the relation of the blood-pressure changes to the respiratory vibrations is the same as in the clinical cases with increased intracranial tension, namely, a rise of pressure with each group of respirations and a fall with each period of apnea. In the experiments during each respiratory group the blood pressure rises above the line of intracranial tension, and with each period of apnea it falls below this line. With the disappearance of this relation the periodicity of the respirations likewise disappears. It is probable that the same relation between the blood pressure and intracranial pressure exists when Cheyne-Stokes respiration occurs clinically in association with increased intracranial tension.

(3) Disappearance of the periodic respiratory activity in the clinical cases of both groups is accompanied by disappearance of the waves of blood pressure.

(4) The waves of blood pressure cannot be regarded as a mechanical effect of the periodic respiratory activity. On the contrary, the latter must be due to the changes of blood pressure, or both phenomena may be referable to a common cause.

(5) Cheyne-Stokes respiration in states of increased intracranial tension, with blood-pressure waves rising and falling above and below the line of intracranial tension, is due to periodic activity of the respiratory, vasomotor, and cardio-inhibitory centers, the underlying cause of which is an alternate anemia and blood supply to the medullary centers. The vasomotor center, as the result of periodic increase and decrease of the stimulus, shows periodic variations in its activity. It is stimulated to greater activity during the periods of anemia and partially relaxes with each period of blood supply. During the periods of anemia the respiratory center loses its irritability for the acting stimulus, and is therefore apneic. It is finally stimulated to activity either as a result of an increase in its irritability from a preceding rise of blood pressure or from a great increase in the respiratory stimulus. The cardio-inhibitory center is stimulated by the periods of anemia. This stimulation causes slowing of the pulse, which passes off to a considerable extent with the following period of blood supply.

(6) Cheyne-Stokes respiration has heretofore been regarded as always the manifestation of the same conditions and capable of the same explanation. The results of this work, on the contrary, show that two distinct groups of cases may be recognized, depending upon the relation of the blood-pressure changes to the periodic respiratory activity.

(7) The medullary centers show great differences in their susceptibility to anemia. The respiratory center is very susceptible to a much reduced blood supply; its irritability is rapidly reduced or lost upon the occurrence of marked or complete anemia, and is rapidly regained when the blood supply is renewed if the anemia has not been maintained too long. The effect of a considerable anemia upon this center is entirely different from that of a normal or somewhat reduced supply of blood which is more venous than

normal, that is, contains more carbon dioxide and less oxygen, such as occurs with ordinary asphyxia. The vasomotor and cardio-inhibitory centers are not nearly so susceptible to anemia. The former center may and frequently does respond in a condition of complete anemia.

(8) I am able to confirm as a result of my experiments upon cerebral compression in all essential details the conclusions of Cushing and the general law formulated by him, namely, that "an increase of intracranial tension occasions a rise of blood pressure which tends to find a level slightly above that of the pressure exerted against the medulla."

* * *

THE ANALYSIS OF 808 CASES OF CHOREA, WITH SPECIAL REFERENCE TO THE CARDIO-VASCULAR MANIFESTATIONS.

Thayer (*Journal of the American Medical Association*, October 27, 1906) gives the result of his analysis of all the cases of chorea at the Johns Hopkins Hospital Dispensary and in the Johns Hopkins Hospital. Of the 808 cases, 698 were treated in the dispensary, 110 in the wards of the hospital. Of these cases, 783 were white, 25 were colored, 232 were males, 576 females. As regards age, 84.5 per cent. of the cases were between 5 and 15. The conclusions of this interesting article are as follows:

A consideration of these cases would suggest that well-marked febrile manifestations without rheumatism occurring during the course of chorea, especially if they be associated with undue rapidity or irregularity of the pulse, should be regarded as at least strongly suggestive evidence of acute endocarditis. It may, of course, be possible that such fever is but the index of an infection which lies at the bottom of the choreic manifestations as well as the associated endocarditis. Slight grades of fever were, it is true, observed in almost every case treated in the wards of the hospital. There is nothing, however, in these studies to justify conclusions with regard to the old question as to whether endocarditis in chorea represents a secondary infection or a special localization of an infectious agent which is responsible for the essential manifestations of the disease.

The most important and interesting part of this investigation remains to be carried out, namely, the study of the circulatory conditions in old patients, but it may not be amiss to call attention again to certain points of interest brought out by this preliminary analysis.

(1) Of 689 cases of chorea observed at the Johns Hopkins Hospital or Dispensary during one or more attacks, 25.4 per cent. showed evidences of cardiac involvement. Such evidence was present in over 50 per cent. of the patients studied in the wards of the hospital.

(2) Cardiac involvement occurred with somewhat greater frequency in those cases in which there was a history of acute polyarthritis than where such history was absent.

(3) Cardiac involvement was commoner in cases of chorea with frequent recurrences than in those in which there was a history of a single attack.

(4) In 110 cases of chorea treated in the wards of the hospital there was fever of a moderate extent in almost every instance.

(5) In a large majority of the cases in which high fever was present there was evidence of cardiac involvement.

(6) There is good reason to believe that the presence of fever in otherwise uncomplicated chorea is in a large proportion of cases associated with a complicating endocarditis.

A Treatise on Diagnostic Methods of Examination. By Prof. Dr. H. Sahli of Bern. Edited, with additions, by Francis P. Kinnicutt, M.D., Professor of Clinical Medicine, Columbia University, New York, and Nathaniel Bowditch Potter, M.D., Visiting Physician to the City Hospital and to the French Hospital, and Consulting Physician to the Manhattan State Hospital, New York. Octavo, 1008 pages, profusely illustrated. Cloth, $6.50 net; half morocco, $7.50 net. Philadelphia and London: W. B. Saunders & Co.; Baltimore: Medical & Standard Book Co. 1905.

Sahli's very extensive, not to say volunminous, work on diagnosis has been well and favorably known by Germans and students of German ever since the publication of the first edition in 1894 under the title "Lehrbuch der klinischen Untersuchungs-Methoden."

Dr. Sahli's more than common equipment for authoritative publication in diagnosis lies in the fact that he is not only a close, careful and accurate observer of morbid phenomena, but a very competent laboratory worker and chemist, as well as the inventor of many instruments of precision.

The close association of the laboratory and bedside methods is the best of the many excellent features of the book—a mutual intercalation effected by both text and arrangement. Indeed, the laboratory methods are demonstrated with such thoroughness as to constitute in themselves material for a manual of laboratory diagnosis. The arrangement of subheadings is admirable in facilitating reference to any individual symptom. Among the instruments and methods original with Dr. Sahli may be mentioned the hemometer and the butymetric method of gastric analysis. The author has a wholesome skepticism of certain diagnostic methods. In particular he criticises cryoscopy, which, he thinks, has little to promise over the older-established methods. His skepticism at times is slightly extreme. For example, the reviewer must take issue with him on the statement that "the height of the liver has little diagnostic value," as a case is recalled where a liver abscess was successfully located and aspirated by this sign, together with auscultatory changes. Post-mortem, the abscess proved no larger than a chestnut and was located in the extreme dome of the liver.

The notes and commentaries of the American authors have greatly improved the value of the text.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

COUNTY SOCIETY MEETINGS.

THE Anne Arundel County Medical Society held a very interesting and profitable meeting on January 8, 1907, at the Hotel Maryland, Annapolis, Md.

The meeting was called to order by the president, Dr. H. B. Gantt of Millersville; secretary, Dr. L. B. Henkel of Annapolis. Routine business was transacted, after which the following papers were read:

"Mechanical treatment of laryngeal diphtheria," Dr. H. C. Davis of Baltimore.

Dr. L. M. Allen of Baltimore gave a lengthy talk on "Puerpural infection, its causes and prevention."

Dr. W. H. Hopkins of Annapolis read a report of some surgical cases.

All these papers were followed by lengthy discussions of interest to the medical profession.

The election of officers for the ensuing year was as follows:

President—Dr. H. B. Gantt, Millersville.

Vice-President—Dr. W. C. Claude, Annapolis.

Secretary—Dr. L. B. Henkel, Jr., Annapolis.

Treasurer—Dr. F. H. Thompson, Annapolis.

Censors—Two years, Dr. T. H. Brayshaw; one year, Dr. J. M. Worthington and Dr. W. S. Welch.

Delegates to State Faculty—Dr. T. H. Brayshaw; alternate, Dr. W. H. Hopkins.

Those present at the meeting were Drs. W. S. Gardner, L. M. Allen, H. C. Davis of Baltimore; T. H. Brayshaw, Glen Burnie; Billingslea, Armiger, F. H. Thompson, Hopkins, Murphy, L. B. Henkel, Jr., and others.

A MEETING of the Allegany County Medical Society was held January 8, 1907, at the Hotel Gladstone, Frostburg, Md., at 2 P. M., Dr. S. A. Boucher, president, in the chair. The program was as follows: Regular order of business. Papers and report of cases: "Diphtheria, with report of cases," Dr. J. H. Carpenter; "Report of gunshot wounds, with some interesting features," Dr. A. H. Hawkins; "Meningitis as a complication of whooping-cough," Dr. J. C. Cobey.

A resignation from Dr. C. H. Brace was accepted, and the following new members elected: Dr. F. L. Barkdall, Cumberland; Dr. A. R. Walker, Frostburg.

SOME FACTS THAT PHYSICIANS SHOULD KNOW IN REFERENCE TO VACCINE AND VACCINATION.

By Dr. W. F. Elgin,

Glenolden, Pa.

PAPER READ AT THE SEMIANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY AT ANNAPOLIS, MD., SEPTEMBER 27-28, 1906.

As suggested by the title, the subject of this paper is to bring to the attention of physicians certain facts as to the character of vaccine and the limitations governing its use.

For the better understanding of the subject a brief sketch of the history of vaccination and a comparison of the former and present methods of preparing the virus are necessary.

Following Jenner's teachings, humanized virus was used in England up to near the end of the last century. For two important reasons this has been largely discontinued—first, because of the lack of material in handling epidemics, and second, because of the possibility of conveying human diseases.

Troja in Italy introduced animal vaccination in 1805, and he was succeeded by Galbiati. They practiced what was known as retrovaccination. The vaccination of animals direct seems to have been first practiced by Negri, successor to Galbiati, in 1842. When this method was introduced into the United States the virus was dried on goose quills; later ivory or bone points were substituted, and these were charged direct from sores on the animal.

Because of the crude methods employed, sepsis frequently complicated the disease on the animal to such an extent as to completely overshadow the vaccinal eruption, and it was often a question whether the latter was present or not. As might have been expected, human vaccination with this virus was frequently attended with excessive inflammatory reaction.

Following the investigations of Chambon and Menard of Paris, Leoni of Italy, Copeman of England, and Drs. Reed and Kinyoun of this country during the latter part of the nineteenth century, glycerinated virus came rapidly into use—first, because of the preservative properties of the glycerine, and second, because of a constant, though slow, elimination of bacteria was noted.

With this change in the method of preparation came greater care in the selection of animals and better protection from extraneous influences. Stables, positively filthy before, are now scrupulously clean; modern surgical methods are now applied to the operating-room, and the whole is controlled by the microscope and appropriate cultural methods.

In making these changes several points came into prominence which applied alike to the vaccination of man and animal:

1st. The preparation of the virus already alluded to.

2d. The results obtained by proper cleanliness in vaccinating the animals emphasize the necessity of like care in human vacci-

nation. Carefully-prepared virus amounts to but little if the physician uses careless and filthy methods in its inoculation.

3d. The character of the incision. Authorities differ as to the size and number of incisions. In Germany and in most of Europe from four to six insertions are insisted upon. In England physicians are instructed by the local Government Board to require the vaccinating doctors to make four inoculations, and the sum total of vaccinated area must equal one-half square inch. This, they believe, is necessary to insure a lasting immunity by vaccinating to saturation.

As you are aware, the custom in this country is to vaccinate at one point only, but the size of the scarification frequently covers the English rule, and occasionally, I am sorry to say, this is exceeded by a large margin.

There may be a difference of opinion as to the number and size of the scarifications, but there can be no two opinions as to the *depth* of the *incision.* According to former methods, on animals the deep incision was used. I have vaccinated animals when the flow of blood was so great as to run down the animals' legs to the floor. This form of inoculation and the infected virus which we were compelled to use as seed frequently resulted in a septic condition in less than three days, with an accompanying discharge and odor that was simply nauseating. With the present seed virus and the shallow incisions this condition has not been seen on the last 5000 animals vaccinated.

Our aim is to *never* draw blood over the whole vaccinated area, and if we could convince the physician of the importance of this rule in human vaccination fewer unnecessary sore arms would be noted.

IMMUNITY.

Time does not permit of an extended discussion, nor is it necessary. Attention is only called to a few points in reference to the character of immunity conveyed by vaccination.

In the first place, it must be remembered that vaccination produces an *active* immunity, that is, an immunity such as is conferred by an attack of any acute contagious disease, such as measles, scarlet fever, etc. Like these, it is specific. A child having an attack of scarlet fever suffers from a series of definite symptoms. During this attack there is an immunity established, so that 12 months later, if the child is exposed to the same disease, he is usually no longer susceptible.

So with vaccinia. In the little tube or point that is sent out from the laboratory no immunity is present—simply the seeds of a disease which, when inoculated on suitable soil, will give definite symptoms, which are readily recognized by the physician under the name vaccinia. And in order that the patient can manufacture his own immunity in this way it is necessary that an impression be made on the general system to bring about the desired results. I have very little faith in vaccination in primary cases that does not make the patient sick and from which we can see no resulting scar.

Do not confound this condition with septic infection. A sore arm cannot confer an immunity unless it is the specific sore of cowpox, from which we get the specific immunity to cowpox and smallpox as well. Physicians should, therefore, always examine the vaccinated subject carefully between the eighth and twelfth day to note the character of the resulting scar before issuing the certificate of immunity.

The question is often asked, how long will immunity conferred by vaccination last? A direct answer to this question is, of course, impossible because of the personal equation, but I have prepared a chart which, while it is entirely schematic, may help to the better

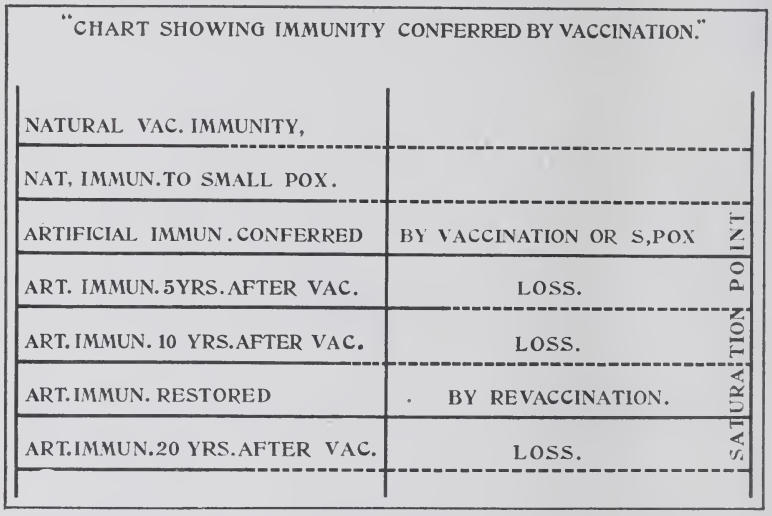


PLATE No. 1.

Entirely schematic. Perpendicular line to the left represents the entire absence of immunity to both vaccinia and smallpox; the central perpendicular line represents the smallpox immunity, while the perpendicular line to the right represents the actual point of saturation to both smallpox and vaccinia.

understanding of this point. From this it will be noted that vaccination in infancy and again at puberty will usually give adequate protection. Should exposure to smallpox be suspected, subsequent revaccinations are imperative. A few persons are refractory to vaccination, but it must be borne in mind that the continuance of this immunity is very uncertain, and the subject should be revaccinated whenever exposed to smallpox until a "take" is secured.

BACTERIA IN VACCINE.

A relatively large number of bacteria is obtained from fresh vaccine by the usual cultural methods. These organisms have no connection with the development of a normal and typical vesicle, and have therefore been called by Copeman "extraneous germs." Their usual source is from the skin of the animal, or they may be introduced during the various manipulations necessary to a completed product.

When care is taken in the preparation of the virus these are usually limited to a few varieties. In freshly-prepared virus the staphylococcus, usually the aureus, and frequently the albus as well, is always present. Some form of the streptococcus is nearly always found, and an organism called by Nakanishi the "bacillus variabilis lymphae vaccinalis" is usually noted. Certain forms of the intestinal flora are occasionally seen.

Laboratory workers have for some time been trying to devise some means to eliminate the extraneous organisms without injury to the virus. A great advance was made when the admixture of glycerine with vaccine material was adopted. This was first done in European countries simply as a preservative, but investigations by Leoni in 1889, Copeman in 1891, Chambon and Menard in 1892, and other European investigators, and Reed, Kinyoun, Huddlestone, and Rosenau in this country have shown that the elimination of germ life takes place slowly.

Most investigators, however, have placed but little stress on heat as a factor in the clearing-up process, and no special mention is made of the fact that cold delays this action almost indefinitely. In 1900 I read a paper before the American Public Health Association, going into this phase of the question in detail and from which the following is quoted:

"3. That glycerine will not destroy the extraneous bacteria in lymph when stored at or below the freezing point.

"4. That continued exposure of germs to low temperatures when constant does not destroy their activity and but slightly decreases their number."

Continued experiments since that time confirm these statements. In fact, virus which had been kept in cold storage at a temperature of about —12° C. for four years, when removed contained staphlococcus aureus, and a 24-hour bouillon culture of that organism inoculated intravenously into a rabbit showed the organism to be still pathogenic.

To bring this phase of the question more clearly before you I have prepared a series of plates from virus taken July 16, 1906, and prepared according to the usual method. Sample No. 1 was placed at 60° C. and a capillary tube removed at 5, 10, 20, and 30 minutes; sample No. 2 was placed at 55° C. and a tube removed at the same periods of time; sample No. 3 was placed in an incubator at 37° C.; sample No. 4 was placed at room temperature from 23° to 30° C., and sample No. 5 was placed in the ice chest at 10° C. A capillary tube of each separate sample was plated at stated intervals to determine the rapidity of the destruction of bacteria under the several conditions noted. An inspection of the plates revealed the fact that virus exposed to 60° C. was clear in 30 minutes; virus exposed to 55° C. still showed 69 colonies in 30 minutes; virus stored at 37° C. had only one colony at the end of three days; virus stored at room temperature showed four colonies at the end of three weeks and was free at the end of five weeks, and at 10° C. was clear in nine weeks.

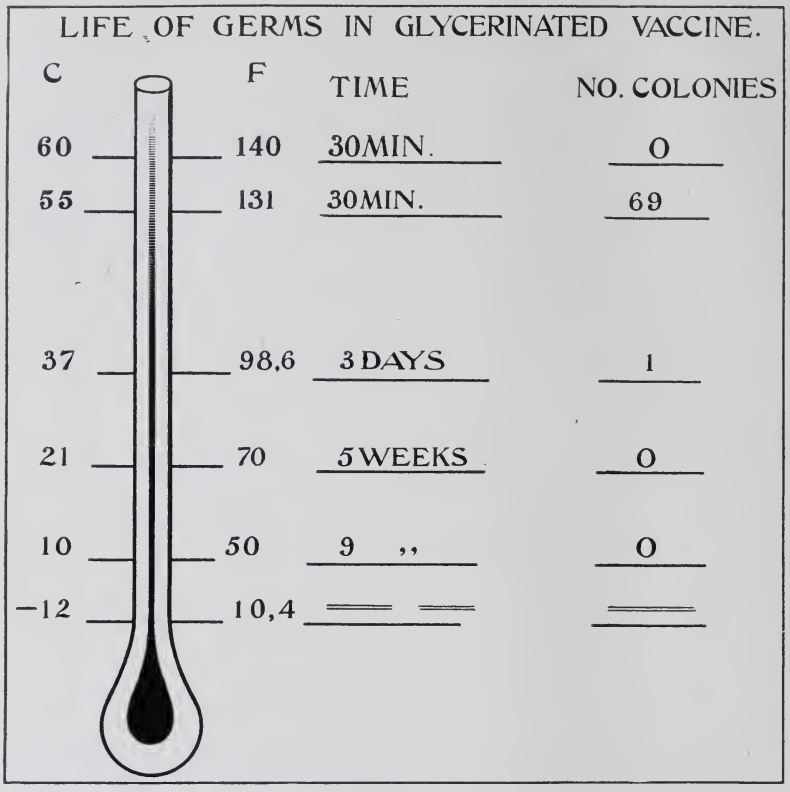


PLATE No. 2.

Showing the effect of varying temperatures on the bacteria contained in glycerinated virus. —12° C. temperature found in the last line was not carried out, as a four years' exposure showed a large number of bacteria still present.

Thus we have a range in temperature of from 60° C. to 10° C., and a range in destruction of bacteria from 30 minutes to 9 weeks. As has already been demonstrated, had samples been placed at —12° C. in all probability the bacteria would have remained for years instead of weeks.

The point which I attempt to bring out in this series of experiments is the fact that the destructive action of the glycerine on the bacteria in the glycerinated product depends largely upon the temperature at which the material is stored. At the temperature at which this is usually stored this takes two months or longer, though, fortunately, the pathogenicity of the contained staphylococcus and streptococcus is usually lost long before the death of the germ, so that these organisms in glycerinated virus stored at from 10° to 15° C. for two or three weeks are frequently benign, as is proven by intravenous inoculations into rabbits of 24-hour broth cultures.

LIFE OF THE VACCINE.

Intimately associated with the problem already suggested is the question of the life of the vaccine itself. Several factors enter into this phase of the question—the condition of the animal, strain of virus, character of "take," method of preparation, and temperature at which it is stored. This last is by far the most important.

I have a chart showing that a temperature of 60° C. will destroy the virus in five minutes, and a temperature of 55° C., while it does not always destroy it, frequently affects the character of the material. Exposure to 37° C., or blood heat, will kill it in from three to four days; to room temperature (23° to 30° C.) will show loss of activity in from one to three weeks, and in ice-chest temperature (10° C.) it will remain active from three to six months, sometimes longer. At —12° C. it has kept for four years, and when removed and kept under ordinary conditions retained its activity for some time.

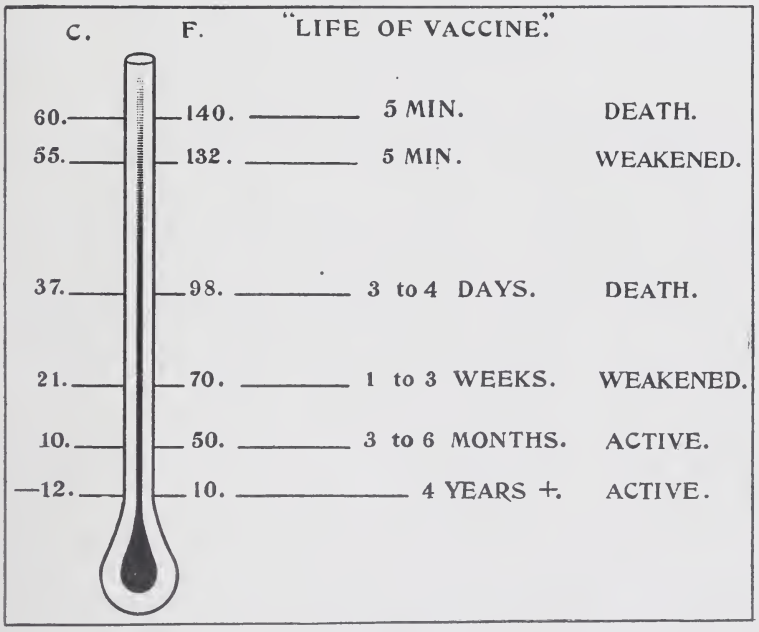


PLATE No. 3.

Showing effect of varying temperatures on the active principle of vaccine in glycerinated virus.

Here we have a range in the activity of from five minutes to four years, according to the temperature at which the virus is stored. I wish you to note in this connection the close relation existing between the contained bacteria and the life of the vaccine itself. This will give you an idea of the difficulty of clearing out the extraneous bacteria and at the same time preserving the virus intact. That this can be done in the laboratory there is no ques-

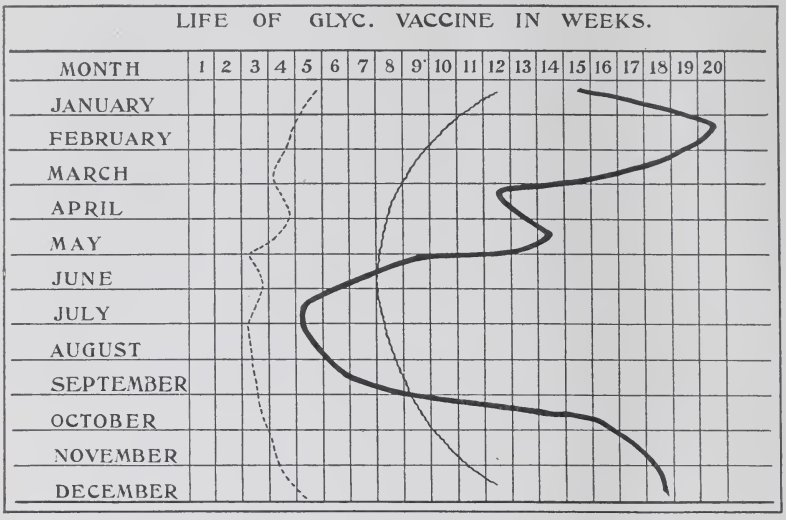


PLATE No. 4.

Black Line—Life of vaccine collected throughout the year.
Curved Line (Schematic)—Life of bacteria in these vaccines.
Dotted Line—The pathogenicity of staphylococcus in these vaccines.
(This chart is based on two years' routine testing of vaccine and represents over 225 samples or 1,500,000 vaccinations.)

tion, but it is extremely difficult to do this and have the virus withstand the trade conditions that exist in the United States.

The important feature for the doctor to understand is the fact that vaccine is some form of life, is controlled by the laws of *life* and *death;* that it is easily affected by heat, and that every care should be taken in the transportation and storage of the product, so that it will not be destroyed in this way. The doctor should not carry it around in his vest pocket nor put it in the table drawer in his office; he should not depend on the druggist to supply him in hot weather, but should order direct from the laboratory, and use the virus as soon after its receipt as possible.

In this way only can he avoid the trouble of failures so worrying and sometimes disastrous during the heated term preparatory for issuing the certificate to school children. It is unfortunate that in this country these certificates are required on the first of September when the bulk of material used is made, shipped and used in the hot weather. In Germany the children are vaccinated in the spring, and few complaints of this character are noted.

DATING OF VACCINE.

In this connection permit me to call attention to the date on the package of virus. From what has been said you can see that it is impossible for the director of a vaccine laboratory to foretell absolutely when a given specimen of virus is going to fail. The dating is simply fixed arbitrarily in compliance with the requirement of the United States Government, and according to such data as we

have at hand to determine the usual length of time virus will remain active under given conditions. The doctor should pay but little attention to this date further than to see that the time has not expired, but should use the virus as soon as possible, as has already been suggested.

A number of questions of interest to the practitioner suggest themselves, but time does not permit of an extended discussion.

Permit me, in conclusion, to call attention to the important features of this paper:

First. Rigid cleanliness should be exercised in human vaccination.

Second. Deep incisions must be avoided.

Third. Glycerinated virus is the best form of vaccine prepared at the present time.

Fourth. Careful instructions should be given the patient as to the subsequent care of the vaccination.

Fifth. Careful examination of the vaccinated site from 8 to 12 days after the operation should be made to determine the character of results and the certificate issued accordingly.

Sixth. Use only fresh vaccine when compelled to vaccinate in hot weather, and if necessary to store it, put it in the coldest place obtainable.

If these instructions are carefully followed but little difficulty will be experienced in routine work of this nature.

A CASE OF ANTERIOR MEDIASTINAL NEW 'GROWTH WITH A NEW (?) PHYSICAL SIGN OF ANEURISM OF THE AORTIC ARCH.

By Gordon Wilson, M.D.,

Chief of the Medical Dispensary and Associate Professor of Clinical Medicine, University of Maryland; Visiting Physician to the Hospital for Crippled and Deformed Children; Visiting Physician to the Maryland Hospital for Consumptives.

PAPER READ AT THE ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY APRIL 25, 1906.

THE case I show you today is of interest not only on account of its comparative rarity, but also from the fact that there has been apparently no increase in the size of the tumor in 18 months and an almost complete disappearance of symptoms with the establishment of the collateral circulation after the more or less complete obstruction of the superior vena cava.

The patient, H. B. F., applied for treatment at the University of Maryland Dispensary on October 8, 1904, complaining of swelling of the face and neck. He was a farmer living in Baltimore county, aged 46, married. The family history was negative as to tuberculosis, specific or malignant disease. He had had the usual diseases of childhood without sequela; denies "specific" disease. Had pleurisy in July, 1900, and was treated at this dispensary, the history showing him to have had a friction rub in lower right axillary region. Has never used alcohol or tobacco to excess.

He first became aware of the present trouble about six weeks before coming to the dispensary.

One day while burning some brushwood he felt that his collar was too tight and was choking him, and since then has noted the same on doing any moderate amount of exercise. His family later observed that his face seemed swollen.

He noticed two weeks before coming into the hospital that there had appeared on his chest several areas, of about the size of a silver dollar, of blue veins. He had no pain nor tenderness anywhere, no cough, no dyspnea, save that on exercising he felt like someone was squeezing his neck; appetite good, bowels regular, no digestive symptoms, no headache, no dysphagia. For some time had had a tendency to clear his throat. There had been no change in his voice. His physical examination disclosed the following: On being stripped to the waist one noticed at once that from the costal margin in front and from the angle of the scapulae behind, up to and including the head and upper extremities, that there was a diffuse moderate cyanosis, accompanied by a moderate edema, save over the first and second right interspaces, where the edema was very marked. There was no Romberg's sign. Pupils were equal, moderately dilated, and reacted to light and accommodation. Mucous membrane of mouth and throat negative, save for cyanosis. There were no glands to be felt in the neck or axilla, and no tracheal tug was made out. The heart was not enlarged or out of position, the apex beat being in the fifth interspace about an inch inside of midclavicular line. Sounds clear at apex and base, though second aortic much louder than second pulmonic. Radial pulse regular in force and rhythm, small volume and tension. Smaller volume apparently in both left radial and axillary than in right, though at a later visit the blood pressure in both arms was found to be the same, namely, about 118 mm. with the Riva Rocci instrument, with two-inch cuff. Over front of chest were noted numerous areas of distended veinules varying from one and one-half to two and one-half inches in diameter. On percussing the upper front of the chest there was found an area of dullness extending downward from sternal notch a distance of 4 cm. and to either side of midsternal line a distance of 5 cm., the area being semicircular in outline, with the convexity downward. This area was distinctly more flat on percussion to the right than to the left of the sternum. Over this area the breath sounds were distant and the transmitted voice sounds were high pitched, distant, and had a slight nasal quality. The balance of the chest, front and back, was negative on auscultation and percussion. In addition to the above there was noted a cordlike structure in the right side of neck corresponding in position, and feeling like a thrombosed external jugular vein; also a slight distension of the superficial epigastric veins. The walls of the large veins of both upper extremities were extremely thickened, feeling like thickened arteries. An *x*-ray picture showed a shadow corresponding to the area described above, while the fluoroscopic

examination showed that the mass did not pulsate, and extended distinctly more to the right than to the left, and was distinctly nodular in outline.

I am indebted to Dr. Gichner for the following facts taken from his history after his admission to the hospital for one week: His temperature range was from 97° to 99°. Examination of urine negative. Blood examination showed the hemoglobin to be 86 per cent. and the red-blood cells to be 4,800,000. There is no record on the history of the number of white cells, though I remember a count was made and that the number was between 5000 and 10,000.

From that time up to today the patient has been intermittently taking potassium iodide, at first being kept very quiet, but gradually exercise increased, depending on the amount required to bring on the choking sensation.

Within six weeks of his admission to the hospital his edema and cyanosis passed off, and since then the only change has been a gradual enlargement of the superficial veins of the front of the chest, as shown in the accompanying photograph. He has now no symptoms, save that on any sudden or very severe muscular effort he still has a slight choking sensation.

In a splendid paper on "Intrathoracic Tumors," published in the tenth volume of the *Transactions of the Association of American Physicians,* Pepper and Stengel discuss the tumors of the anterior, middle and posterior mediastina, and demonstrate the fact that the majority of the tumors are sarcoma and probably arise from the remnant of the thymus gland. Hare previous to this had reviewed the literature and found 134 cases of cancer and 98 cases of sarcoma, but, as Pepper and Stengel point out, the majority of the cancer cases were reported prior to 1870, "when the term cancer was used with notorious laxity," and also the fact that only three sarcoma cases were reported prior to 1870. These authors also investigated 25 of the cases classed as cancer, and found in "13 of these unquestioned evidence of the sarcomatous nature of the disease."

In the differential diagnosis of tumor from aneurism they emphasize three points: First, age of patient—tumor found at an earlier age than cancer; second, pain less common with tumor; third, occlusion of the large veins much more common in tumors than in aneurism.

Of course, now we have an almost infallible differential diagnostic point in that we can see by means of the fluroscope whether the tumor pulsates or not.

While studying this case I was struck with the fact of how much more quickly and more accurately I could map out the area of dullness by listening to the transmitted voice sounds than I could by percussion, and since then have been trying this method on the cases of aneurism of the aortic arch that have come under my observation. I have had so far three cases of aneurism of the aortic arch and one case of aneurismal dilatation accompanying

aortic insufficiency. In none of these four cases was there external evidence of tumor or pulsation noted.

As in the case I show you today of aneurism of the aortic arch, there was noted the following:

On listening with an ordinary bell of a biaural stethescope at the extreme right of the first interspace in front while the patient says "one," one notes the normal transmission of the voice sound. As you gradually move the bell in the first interspace towards the sternal border you come to a point at least half an inch from the sternal border, where the transmitted voice sounds suddenly change, becoming more distant, higher pitched, and having a slight nasal quality. In this patient this area extends 5 cm. to either side of the midsternal line in the first interspace.

Dr. H. D. McCarty and myself have been trying this method on the normal cases at the University of Maryland Dispensary, and in most of the cases the nasal quality is noted only over the sternum, and in none did it extend as much as one-half an inch beyond the sternal border.

This may not be a new sign, as I have not carefully reviewed the literature, having only so far looked over most of the bound volumes at the Medical and Chirurgical Library dealing with diseases of the heart and arteries, and have as yet made no attempt to look up individual articles in the medical journals.

This paper is presented on too few cases, but in the hope that others may confirm or disprove this sign.

SOME OBSERVATIONS ON THE SIGNIFICANCE OF THE SO-CALLED "OCCULT HEMORRHAGES" IN THE DIAGNOSIS OF ULCER AND CARCINOMA OF THE STOMACH.

By Julius Friedenwald, M.D.,

Professor of Diseases of the Stomach, College of Physicians and Surgeons.

and L. J. Rosenthal, M.D.,

Demonstrator of Diseases of the Stomach, College of Physicians and Surgeons, Baltimore, Md.

PAPER READ AT THE ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY APRIL 25, 1906.

It is our desire to call attention to the significance of two very simple tests, the importance of which was first pointed out a few years ago by Boas as a means of detecting minute quantities of blood in the gastric contents and feces. This investigator showed that by aid of the well-known Weber test, as well as by Klunge's aloin test, it is a simple matter to detect a minute quantity of blood having its origin in the stomach too insignificant to be seen by the naked eye and yet which, by its continued persistence, may prove a serious menace to life.

In his first communication Boas pointed out the fact that that form of bleeding which was too insignificant to be detected by the naked eye, and which he termed "occult hemorrhage," occurred only in certain gastric conditions. He never found it in the gastric contents in chronic gastritis, hyperacidity, or hypersecretion; it occurred occasionally in gastric ulcer with or without consecutive stenosis; it always occurred in cancer of the stomach, as was shown by an examination in 20 cases.

In a further communication Boas showed that errors due to slight bleedings induced by introducing the stomach tube, causing minute erosions, could be avoided by investigating the feces rather than the gastric contents. However, in the examination of the stools for these hemorrhages certain precautions must be taken, namely, to exclude food containing fresh unboiled or medium-done meats and sausage from the diet for two days before the test is undertaken, as well as to ensure soft movements by means of Carlsbad salts. Occult blood was not found by us in 92 examinations in 47 cases of chronic gastritis, in 42 examinations in 15 cases of atony of the stomach, in 108 examinations in 42 cases of hyperchlorhydria, in 21 examinations in 8 cases of hypersecretion, in 16 examinations in 9 cases of acute gastritis, in 57 examinations in 25 cases of nervous dyspepsia. So significant is the fact that we have frequently been enabled to rely on the constant absence of this sign as evidence sufficient to exclude the presence of ulcer and cancer, and, on the other hand, as evidence in favor of the presence of either a gastritis or some form of gastric neurosis.

Thirty-five cases of ulcer of the stomach were examined as to the presence of occult blood in the stools. This condition was found in 26—74 per cent. It was not noted, however, at every examination; most frequently, however, before the patient had been placed under treatment and when the pain and nausea were extreme. After the patient had been placed upon the ulcer cure (rest in bed and a diet mainly of milk) for a period of days the occult bleeding usually disappeared. The continuance of occult bleeding after a faithful trial of the ulcer cure has been undertaken is indicative of the fact that a healing of the ulcer is impossible, and surgical interference must then be considered. We have found occult bleeding a most valuable aid in diagnosis of this disease, especially in the cases in which the symptoms are not decisive and in which the diagnosis varied between gastralgia and ulcer. In every instance in which the ulcer treatment was undertaken improvement in the patient's condition indicated the correctness of the diagnosis and the value of this sign. Occult bleeding has often as much significance as pronounced hemorrhage and will frequently indicate the presence of an ulcer long before visible hemorrhage is present.

The presence of occult blood can be utilized, too, in testing the effect of various forms of treatment in ulcer of the stomach. During the ulcer-rest cure the occult bleeding rapidly disappears. On the other hand, Schloss has shown that bismuth, which was for-

merly considered to have a specific effect in the treatment of this disease, can no longer be considered in this light.

Twenty-three cases of cancer of the stomach were examined by us for occult bleeding. In but very few examinations was the absence of this sign noted. It was found constantly in 19 of the 23 cases—82.6 per cent. In the other four this symptom was occasionally noted. So constant is this finding that it serves to differentiate cancerous processes of the stomach from other conditions.

Occult bleeding is found early in the disease often long before the physical signs of a tumor become manifest. While the presence of this sign alone, however, has no significance, in addition to other clinical evidence, we have found it of such practical value that we should urge a careful investigation for occult bleeding in all obscure forms of gastric disease.

REPORT OF THE MEETING OF SECTION ON CLINICAL MEDICINE AND SURGERY.

FRIDAY, OCTOBER 19, 8.30 P. M.

Chairman: Randolph Winslow.

Secretary: L. V. Hamman.

Third Member of Executive Committee: Harvey G. Beck.

The first number on the program was the presentation to the Faculty of a volume in memory of Dr. Thomas Sargent Latimer by the Research Society of the College of Physicians and Surgeons.

HEMOCHROMATOSIS WITH DIABETES MELLITUS—*Dr. T. B. Futcher.*

In the past two years there have been two cases of hemochromatosis in the Johns Hopkins Hospital which have terminated in diabetes mellitus. Our first case was a man, 45 years old. There was nothing of interest in the family or past history outside of the fact he had been a heavy drinker. A few months before coming to the hospital he complained of diabetic symptoms. Pigmentation was noticed first on the face, hands, and legs. There was none on the genitalia, axillae, or mammary region. The patient had a very large liver which was firm and easily palpated. There was a large amount of sugar in urine. Reactions for acetone and diacetic acid were obtained. He remained in the hospital a few weeks and went home and died in a few months of diabetic coma. Death occurred 20 months after onset of the diabetes. The date of the appearance of the pigmentation was not known. Evidently it had been a gradual process.

The second was a man, 53 years of age, who showed the same symptoms and physical signs as the last case, only the pigmentation was more striking. He had marked diabetes before entering. This case died later, not in coma, but probably from a pneumonia of the lower left base. The pigmentation had been present for years. The diabetes had existed for six months previous to his death.

Both of these cases conform to cases described by Hanot and Chauffard

in 1882. In 1882 Letulle described two more cases, and in 1886 Hanot and Schachmann suggested the name *diabète bronze* for this form of diabetes and *cirrhose pigmentaire diabetique* for this type of cirrhosis.

In 1889 Von Recklinghausen of Strassburg described a disease which he called hemochromatosis. There was pigmentation of the skin and hypertrophic cirrhosis of the liver; all the lymphatic glands were markedly pigmented; the intestines were of a yellowish color. The tissues showed two different pigments. One was found in the liver, pancreas and lymphatic glands, which gave a positive test for iron. This he called hemosiderin. An ocher-yellow pigment was found in unstriped muscle of the intestines and in the heart, which pigment did not give the test for iron. This was called hemofuscin.

A few years later these cases of hemochromatosis were found to be identical with the cases of bronze diabetes. In 1899, 24 cases were collected by Auschütz, and the conclusion arrived at was that diabetes is a terminal event in hemochromatosis. It is found that the pigmentation gives rise to interstitial pancreatitis and hypertrophic cirrhosis of the liver. Opie showed that an interstitial pancreatitis is present in these cases. He demonstrated that islands of Langerhans are affected. Their glycolitic function is destroyed, and the sugar therefore accumulates in the circulating blood. Bronzed diabetes is not an entity. Hemochromatosis is, however. Not until a certain amount of damage is done to the pancreas does diabetes develop. Hanot and his assistants thought diabetes was the primary factor. It has not been definitely determined whether both pigments are derived from the blood or not. Recent experiments seem to show they are akin and both probably derived from the blood. It is now believed that some unknown toxin causes a destruction of the red cells, with the deposition of the blood pigment in the tissues, causing cirrhosis of the pancreas and liver. We have three cardinal symptoms in hemochromatosis: First, pigmentation of skin or tissues. In all cases not present, though it is generally so. Second, hypertrophic cirrhosis of the liver. Rarely has there been an atrophic cirrhosis of the liver. Third, diabetes mellitus. This is a terminal event and depends on the destruction of the islands of Langerhans. Up to now there have been 35 cases of hemochromatosis with diabetes mellitus reported. These include the two cases here considered. Of these 35 cases, all were men but two. Two cases have been reported since 1899 in women—one of them by Berg of New York and the other by Murri of Bologna.

In Berg's case the patient had exophthalmic goitre. Most cases occur in men and develop between the thirtieth and sixtieth year. Hemochromatosis and cirrhosis of the liver may go on for years and the patient may die before the diabetic stage is reached owing to some intercurrent affection. When diabetes develops it dominates the picture and death usually occurs within one year after its onset.

Some of the Newer Remedies in the Treatment of Gonorrhea—*Dr. M. Rosenthal.*

An antigonorrheic to be of value must not irritate; it must destroy the gonococcus and it must not increase the existing inflammation. Before the etiological factor of gonorrhea was discovered it was found that nitrate of silver acted better in this disease than any other drug. Unfortunately,

nitrate of silver irritates intensely and increases the existing inflammation; it also precipitates in the presence of albuminates and chlorides; it softens the outer layer of epithelium and paves the way for infection of the deeper structures.

Chemists sought various combinations of silver with an agent which would prevent precipitation and which could remain in contact with the sensitive urethra long enough to allow the drug to penetrate the numerous folds and follicles lining the urethra. Argenin, the first to be introduced, is a silver casein compound containing 4.2 per cent. silver. The unstable nature of solutions and the difficult solubility are its disadvantages. Largin, a nuclein proteid, is decidedly irritating, and precipitates with albumen and urine. Argentamin is a solution of silver nitrate and ethylene diamine corresponding to 10 per cent. silver nitrate solution; strongly caustic in action and possesses no virtue over silver nitrate. Protargol, a protein silver, is strongly bactericidal in action and non-irritating. It is the best and safest organic silver compound, and acting as a mild astringent in stronger solutions it has a definite value throughout the course of the disease. Ithargon, a silver ichthyol combination introduced by Merck, is too irritating when used in the strength recommended as a gonocide. Argyrol, introduced by Hilles and Barnes, is a so-called vitellin of silver containing 20 to 25 per cent. silver. It has no superior points over protargol and a number of disadvantages. It stains indelibly anything with which it comes in contact. It is only useful in 10 to 25 per cent. solutions, making the cost of a four or six-ounce prescription decidedly greater than protargol, which is used in ¼ to 1 per cent. solutions. Derby, in a recent number of the *Boston Medical and Surgical Journal,* finds argyrol precipitates in presence of albumen and urine; bactericidal properties weak. It is sterile and soothing, washes away the pus mechanically, does no harm, and does not deter nature from doing her best. Normal salt solutions have the same virtues. Albargin, the latest silver salt calling for recogntion, has thus far proven no advantages over the older preparation.

The *rôle* played by balsams in the treatment of gonorrhea is limited. Copaiba, owing to its disagreeable taste, tendency to cause gastric disturbance, difficulty of absorption and its liability to produce erythema, is but little used at present. Cubebs possess the same disadvantages in a slightly less degree. Santal-wood oil, having none of the unpleasant features of either cubebs or copaiba, is extensively used. Given in large continued doses it may produce pain in the back, with symptoms of renal congestion. The action of these drugs is dependent on the topical effect of the drug-laden urine. They reduce the pain and tend to diminish the discharge, but have no specific action on the gonococcus. Methylene blue given internally for gonorrheas is without value. Given as an agent in suggestive therapeutics it is invaluable. No neurasthenic patient could take the drug without being firmly impressed with the startling results.

MEETING HELD FRIDAY, DECEMBER 7, 1906.

Exhibition of Cases—Dr. W. S. Baer. Case 1—*Sarcoma of the Dura.* Boy, six years of age, taken sick September 26. The mother noticed that he was constantly falling; the next day he stumbled about again, and on the third day became paralyzed from the waist down. Never complained of any pain. The doctor saw him first on October 16, when there was the

following condition: Complete paraplegia of both legs, of the spastic type; both knee jerks exaggerated; ankle klonus very marked; Babinski's reflex marked; almost complete anesthesia going up the body as far as the dorsal vertebra; both eyes dilated but reacting to light; no stiffness of the spine nor pain on pressure. Dr. Thomas saw the case in consultation with Dr. Baer. Pott's disease was at first thought of, and the patient was given two mg. of tuberculin, which was negative. In order to be absolutely sure on this point he was three days later given five mg. of tuberculin, without reaction. Radiograph was taken, showing no lesion of the spine. In order to rule out specific disease he was put on potassium iodide and inunctions, but failed to respond. From the onset of the disease there was a slight temperature, 100-101, some days going down to normal, but immediately going up again. There was no leucocytosis. Specific disease and tuberculosis having been ruled out, as was also Landry's paralysis, it was decided to do a laminectomy and explore the spine. The cord was explored from the first to the fifth dorsal vertebra. The dura immediately bulged into the wound and filled up the space, and projecting out were little rosettes of reddish tissue. On taking one of these and examining it it was found to be round cell sarcoma. The tumor extended down along the cord, and in some places had gone directly into the cord. An interesting feature of the case was that while in the hospital the area of anesthesia gradually ascended from the eleventh to the fourth dorsal vertebra. It had evidently started low down and was gradually ascending. The child had temperature from the onset, which still persists. There is complete absence of pain.

Case 2—*Snapping Joints.* Young lady, 16 years of age, referred by Dr. Beck. Had been fairly well all through childhood. At 10 had St. Vitus dance, which lasted two or three years, was absent several years, and then returned and is present now. The condition of snapping joints began three years ago and has existed ever since. The joints which snap are both shoulder joints, wrist joints and finger joints, which can be snapped voluntarily. Those involuntarily snapping are the hip, knees and feet and elbow joints. Urinary examination was normal. There is slight exophthalmos and goitre. The patient is of highly nervous organism. If she gets her hands wet she suffers agony until she can dry them again. Dr. Baer had thought at first that it might be explained by a weakened condition of the ligaments and muscles, allowing a great deal of relaxation of the joints, with perhaps some synovial thickening. The treatment had been tonic, massage by hand and mechanical vibrator and electricity.

Case 3—*Case of Pott's Disease with Lamanectomy and Complete Recovery.* Patient admitted to the Johns Hopkins Hospital in September, 1905. Had previously been in two years before and had had history of pain in his back two years previously. He had worn a brace, but, feeling better, had left off the apparatus. When he came in in September, 1905, there was a condition of complete paraplegia of the spastic type; legs were crossed; constant patella klonus; knee jerks exaggerated; ankle klonus so great that it kept the bed shaking; paralysis of both arms; double wrist drop, with inability to use hands. Hyperextension was tried until November 25. Did not respond at all to ordinary treatment, and lamanectomy was performed high up. Opposite the second dorsal vertebra there was found a calcareous mass about the size of the little finger—inside the canal, but

outside the cord, pressed firmly against it. On taking up the mass there was a spurting of pus, which led into an abscess in the mediastinum. The mass was removed and the mediastinum drained with gauze. The dura was not opened and the cord not exposed. Wound was closed entirely. Put up in plaster cast, including the head. He had anaesthesia from the knees down and disturbed sensation from the waist down. He began to move the toes in a month. In five months was able to use the legs normally, but was still somewhat weak in the back. Now, 14 months after the operation, he wears nothing for support. Has perfect motion in back, except right at the seat of the ankylosis. Has no temperature now. Dr. Baer believed that there were a certain number of cases where one should not wait too long; if after three months there is no attempt at improvement, he thought it best to do a lamanectomy. X-ray pictures of the case were shown.

Dr. W. S. Halsted, in discussing the cases reported, said, with reference to the last case, that the recovery had been very prompt indeed. Many of the German surgeons, particularly Trendelenberg, were inclined to ascribe their recoveries to operation, even when they had not recovered for six months later. In such cases one might hesitate to ascribe the result to operation, but in this case it was very definite.

As to the etiology of this particular form of snapping joints, which is very different from the ordinary finger snapping, he could not say. He thought with reference to the goitre, that if she had had the atrophic form one might think of a connection between that and the joints, because there is a recognized form of chronic rheumatism due to too little thyroid secretion, but this seemed to be the reverse, too much thyroid secretion.

Is Eye Strain Ever an Etiological Factor in Epilepsy?—Dr. H. O. Reik reported four cases of epilepsy in which the active causative agent appeared to have been eye strain and in which correction of the refraction errors relieved the graver affection. The question expressed in the title of the paper was answered in the affirmative and the author's observation related to show that an epileptic seizure might be induced by reflex action from an ocular disease. It was considered important to determine any agency that might, even remotely, contribute as a causative factor in this disease, because when once firmly established the disease has such a very bad prognosis. Saving an individual from the development of epilepsy or the care of one in whom the disease had started was a very important matter, because if only one case of epilepsy in a hundred should be found to be due to eye disease and curable by the proper treatment of that organ, it became possible to double the present percentage of cures. Neurologists at present considered epilepsy to be due to two factors—a predisposing and an exciting cause. In the majority of the cases both of these causes played a part and were complemental to each other; thus to an hereditary predisposing cause there must be added some exciting cause, and in this list were included the specific fevers, toxemia, emotional shock, trauma or some reflex irritation. Just what the process of reflex action might be was not positively known, but it would seem plausible to assume that through abnormal function of certain organs toxines might be set free, which would seriously injure the delicate structures of the cerebral cortex when brought into contact with it, and thus precipitate an epileptic attack.

Dr. Reik quoted from Sprattling's recent work on epilepsy to show the effect of such reflex exciting causes as dentition, gastro-intestinal disorders,

prolonged anxiety or overwork in the production of epileptic seizures, and thought that if we admit all of these reflex disturbing agents as exciting causes in epilepsy it would be ridiculous to argue against the possibility of eye strain, or nasal irritation, assuming the same pathological role. He said that Dr. Sprattline, having cited cases produced by the other reflexes, had stated that "he had never seen a case in which he felt that defective ocular conditions alone caused epilepsy"; that if he meant by that to eliminate the predisposing factor he was begging the question, for it had not been claimed that eye strain or any other reflex would cause epilepsy in an individual not possessed of that weakened nervous system which predisposes to the disease; but that if he meant that eye strain never produced epilepsy, even in a person predisposed to the disease, he was certainly wrong.

Dr. Reik related in detail the histories of four cases of undoubted epilepsy, two diagnosed by neurologists and two by competent general physicians, in which the relief of eye strain had been followed by the disappearance of the epileptic seizures. The essayist was also permitted to report one case of epilepsy occurring in the practice of Dr. Theobald that had been markedly improved by the use of glasses for two years, then suffering a recurrence of the seizures for a brief period, when a re-examination of the eyes and the prescribing of new glasses again caused disappearance of the epilepsy. He also related a case in the practice of Dr. J. Frank Crouch, a very interesting case of epilepsy cured by the correction of ocular defects, his patient requiring an operation upon the internal rectus muscles as well as the use of glasses.

Dr. Samuel Theobald said that there was no question but that Dr. Reik's position was correct to this extent: That ocular eye strain is a factor in producing epileptic seizures. Of course there must be the predisposition. Unfortunately, however, the matter had been much exaggerated by a few men in this country and England, who had claimed to cure epilepsy by prescribing glasses or by operations on the ocular muscles, and whose claims had not been sustained, so that the whole question had been brought into disrepute, though there was a substratum of truth in the claims. He felt that the essayist had put the matter very clearly. Undoubtedly if a foreign body in the nose and stricture of the urethra could produce epilepsy, the reflex irritation from muscular defects of the eye or errors of refraction could do the same thing. In his own experience he had had but the one case. He had had a number of cases indexed epilepsy, but this was the only one in which the history indicated a definite change for the better as a result of prescribing glasses. He thought, however, that Dr. Reik's cases were interesting and conclusive, as was also the case of Dr. Crouch's. Dr. Theobald had had occasion some time ago to look into the claims that had been made by some men and had found that one patient that was claimed to have been cured of epilepsy by an English authority had never had but one attack, while another had had only a series of attacks in one day. It was safe to assume that these were not cases of epilepsy. In another case what was done for the eyes was so insignificant that it could not have relieved any eye strain. In one case simply a weak concave glass had been given for near vision. Some of the claims that had been made were preposterous. There was, however, undoubtedly a considerable amount of truth in the claim that there are some cases of epilepsy that may be cured by the correction of ocular defects.

MARYLAND MEDICAL JOURNAL.

JOHN S. FULTON, M.D., *Editor.*

Associate Editors:

THOMAS R. BROWN, M.D. | HUGH H. YOUNG, M.D.
ROBERT REULING, M.D. | JOSE L. HIRSH, M.D.

BALTIMORE, FEBRUARY, 1907

WASHINGTON'S TYPHOID EXPERIENCE; AN ENIGMA.

MANY and unconvincing explanations are offered for the apparent failure of a new filtration plant to reduce the typhoid mortality of the District of Columbia. Being generally reliable and always a convenient test of the sanitary quality of water supply, the typhoid mortality has become the chief argument for filtration. When filters have been built for the sake of excluding typhoid, a satisfactory decline of the typhoid figures means satisfaction in the filters. Long before the Washington filters were started, public attention was fixed upon the typhoid index. But when the filters were started, the rooted gaze of demonstrators and witnesses was unrewarded. The index did not respond. The experiment was a failure. *Experimentum periculosum.*

For a youthful professor of chemistry or physics, one such experience suffices; seasoned teachers make sure of their materials and apparatus before the class assembles. Fortunately, the laboratory figures speak directly and unequivocally for the efficiency of the Washington filters, and their testimony would be conclusive even if Washington had been prostrated by epidemic typhoid in 1906. If the desired reduction of typhoid mortality had occurred, a pennyweight or two would have been added to the testimony of the laboratories, but an unresponsive typhoid index does not score against the filters. The efficiency of the filters and the undiminished mortality both suggest that Washington may still have a typhoid problem after the innocence of her water supply is established.

Down to 1902 the typhoid mortality of Washington was remarkable for its extravagance and its inconstancy. Since 1902 the annual tide of typhoid has kept remarkably uniform stages, the mean level remaining as low as in the most favorable years of the city's previous history. This novel phase of Washington's typhoid history becomes more striking if one adds to the typhoid mortality the reported mortality from malaria. For know all men by these presents that malaria is not a cause of death in Washington. Practically every death certificate, alleging malaria a cause of death in the District of Columbia, is either a fiction or a blunder. All the deaths attributed to malaria and typho-malarial fevers may not have been due to typhoid fever, but at least 75 per cent. of them should have been recognized during life, and recorded after death, as cases of typhoid. The figures themselves testify that the medical men of Washington have been coming round gradually to more accurate diagnosis of the continued fevers, for typho-malaria disappeared in 1902, and malaria has dwindled to inconsiderable proportions. If to the typhoid figures we add the malarial and typho-malarial figures we shall represent the actual conditions more truly, and we shall find that, for 20 years before 1902, medical diagnosis, typhoid fever and Potomac waters all led wild careers of insobriety. In 1903 a period of calm ensued, signifying that District doctors and Potomac

waters have definitely abandoned evil ways, while typhoid gives promise of amendment.

Since the operation of the filters in 1906 did not disturb the mean level maintained by typhoid mortality in the preceding three years, the question arises whether a typhoid rate of 42 per 100,000 represents the residual typhoid which Washington may expect after eliminating the influence of Potomac water. This is a question for epidemiologists, and, unfortunately, there are no epidemiologists. There are potential epidemiologists, but actual epidemiologists are not found in the United States. An epidemiologist is a student of epidemic disease. The science of epidemiology, however, does not begin with the study of epidemics, but with a knowledge of the people upon whom epidemic phenomena are wrought. In this fundamental information about her people the United States is poor beyond the dreams of any anchorite. American cities count their citizens, stopping, sometimes, when the people are all counted, and sometimes when civic ambition is satisfied. But having done enumerating, American cities do not ascertain the distribution of the people by age, or sex, or conjugal condition, or occupation, or nativity, or race, except that many cities distinguish between colored and white citizens. Not to know these things is to be unable to calculate an understandable death rate, and most American death rates, whether general or particular death rates, are pitfalls for the unwary. American students, lacking information about the people who are alive, and forced to begin their statistical exercise with imperfect information about the dead, are apt never to arrive as epidemiologists, though they may go down as wise men, like the three of Gotham who went to sea in a bowl. This adventure, like others of the same sort, is perilous, but enticing, and is undertaken with full knowledge of its risks.

Let us learn, if possible, what the typhoid expectancy of Washington is, approximately. It was shown some years ago that urban typhoid is inversely related to population. The great cities, New York, Philadelphia and Chicago, furnish a combined typhoid rate of about 25 per 100,000. Cities of between 200,000 and 300,000 furnish a combined rate of about 35 per 100,000. Washington is in this class, with seven other cities. Situation is another factor in the typhoid expectancy. Eleven nearby cities, having 2,097,495 people in 1900, lost 867 persons with typhoid, the rate being 41.3 per 100,000. These cities are Philadelphia, Wilmington, Baltimore, Annapolis, Frederick, Alexandria, Richmond, Norfolk, Petersburg, Lynchburg and Raleigh. Typhoid is more prevalent in the South. The combined typhoid rate for Baltimore, Louisville, Wheeling, Richmond, Norfolk, Petersburg, Lynchburg, Wilmington, N. C.; Charleston, Atlanta and Savannah in 1900 was 59 per 100,000. If these figures indicate normals, Washington has realized her typhoid expectancy in 1903 and since, if, indeed, her experience has not exceeded reasonable expectation.

It is well known (or ought to be) that typhoid fever is a rural disease, progressing in general from the country to the town rather than from town to country. The typhoid rate of Maryland, exclusive of Baltimore, is often two and a half times as great as that of Baltimore. Potomac waters are polluted by the people of Maryland, Virginia and West Virginia. In 1900 these States had an aggregate population of 4,001,028, and 2010 persons died of typhoid fever. The rate was 50.2 per 100,000. The

rural typhoid mortality is, however, much higher than the figures indicate. This must be true, for the returned mortality for Virginia and West Virginia represents the number of deaths reported from memory at the end of a year. Neither of these States records mortality at the time and place of its occurrence, and the defect on this account is not less than 30 per cent.

So much for the testimony of the dead; now for the evidence of the living. The census figures can be depended on for certain data about the characteristics of American populations. The population of the District has definite features determined by its political relations. At all ages under 15 it is numerically feebler than any American city or any State east of the Mississippi. In each 10,000 people, Washington has 2518 persons under 15, Baltimore 2965, and Maryland 3345. In each 10,000 people the District has 4728 between the ages 15 and 40, while Maryland has 4222. The census figures require this comparison between Baltimore and Washington to cover the years 15 to 45 (instead of 15 to 40), and we find that Washington has 5378 persons in this age period, among each 10,000 of her population, while Baltimore has 5196. This period of life gives the heaviest typhoid mortality, and Washington has a larger population in these ages, 12 per cent. more than Maryland, and 3.3 per cent. more than Baltimore. Other things being equal, Washington ought to have a greater typhoid mortality than Baltimore or the State of Maryland.

The tuberculosis mortality speaks most strikingly for the influence of age distribution and the other peculiarities of the living population of the District, the consumption death rate for whites in the District being 210 per 100,000, while the corresponding rate for whites in the whole country is 173.5 per 100,000.

The negro population of the District (32 per cent.) is greater than that of Maryland (19 per cent.) or of West Virginia (5 per cent.), and less than that of Virginia (35 per cent.). The influence of age distribution of negroes also appears in the tuberculosis mortality. The colored rate for the country is 490, and for the District 513 per 100,000.

In the matter of sex, the District population shows an excess of females from 15 to 40. The District population shows also disproportionate numbers of unmarried persons in both sexes, contrasting strongly in these respects with Maryland, Virginia and West Virginia. Its characteristics as to age, sex, race and conjugal condition would lead one to expect a higher attack rate for typhoid fever, and greater fatality percentage, in the District than in the adjoining States. Two other peculiarities probably affect unfavorably Washington's typhoid expectancy. Disproportionate numbers of her population are engaged in personal and domestic service, as the census figures show. The difference between the day population and the night population of Washington is probably greater than one may find in other cities. Washington distributes no merchandise. The morning exodus of salesmen and of other workers is very small. There is, however, a heavy morning invasion of workers and transient visitors. The working day of Washington is comparatively short, and the afternoon exodus appears to exceed the experience of cities of equal size. These circumstances favor the prevalence of typhoid fever, because the suburban conditions are more dangerous than those of the city.

The mortality statistics show that, with a typhoid rate as low as 42 per 100,000, Washington is not bearing her full share of the losses falling on this part of the country. The reasonable expectancy indicated by the history of typhoid in the vicinity is considerably above 42. To the expectancy indicated by her situation, Washington should add something on account of the special susceptibilities of her living population as revealed by the population statistics. The Capital City should have expected, under all the circumstances, an average annual tax of at least 50 lives in each 100,000. With purification of the water supply, other conditions being unchanged, Washington should be satisfied if the typhoid rate is 40 per 100,000, and delighted if it falls to 35.

To these speculations about the typhoid expectancy, one may add a word about the probabilities of the past year. Philadelphia had a rate of 75 per 100,000 in 1906; Baltimore had about the average mortality, but greater morbidity. Mr. Horton obtained information from Richmond, Norfolk, Cumberland and Atlanta, indicating epidemic prevalence of typhoid throughout the South. Maryland experienced in 1906 a typhoid mortality 16.5 per cent. greater than that of 1905. The typhoid mortality of the States of Virginia and West Virginia is known only to the uncommunicative and non-resident Recording Angel. On the exceedingly conservative estimate that this part of the South had a mortality in 1906 exceeding that of 1905 by 16.5 per cent., Washington should have had a corresponding increase in 1906, giving a typhoid mortality of 49 per 100,000. The District Commissioners cannot remove the capital to a distant and more favorable part of the country; they cannot change the peculiar features of the population; it is doubtful if they can supply much better water. They may look upon a typhoid rate of about 35 per 100,000 as the minimum residual problem, to be solved by searching out causes within the city and praying for Hygiea's merciful intervention in behalf of the people of Virginia, West Virginia, and Maryland.

Book Reviews.

The Life of Dr. Samuel A. Mudd. Containing His Letters From Fort Jefferson, Dry Tortugas Island, Where He Was Imprisoned Four Years for Alleged Complicity in the Assassination of Abraham Lincoln. With Statements of Mrs. Samuel A. Mudd, Dr. Samuel A. Mudd, and Edward Spangler Regarding the Assassination, and the Argument of General Ewing on the Question of the Jurisdiction of the Military Commission, and on the Law and the Facts of the Case. Also "Diary" of John Wilkes Booth. Edited by Nettie Mudd, Daughter of Dr. Samuel A. Mudd. With a Preface by D. Eldredge Monroe of the Baltimore Bar. New York and Washington: The Neale Publishing Co. 1906.

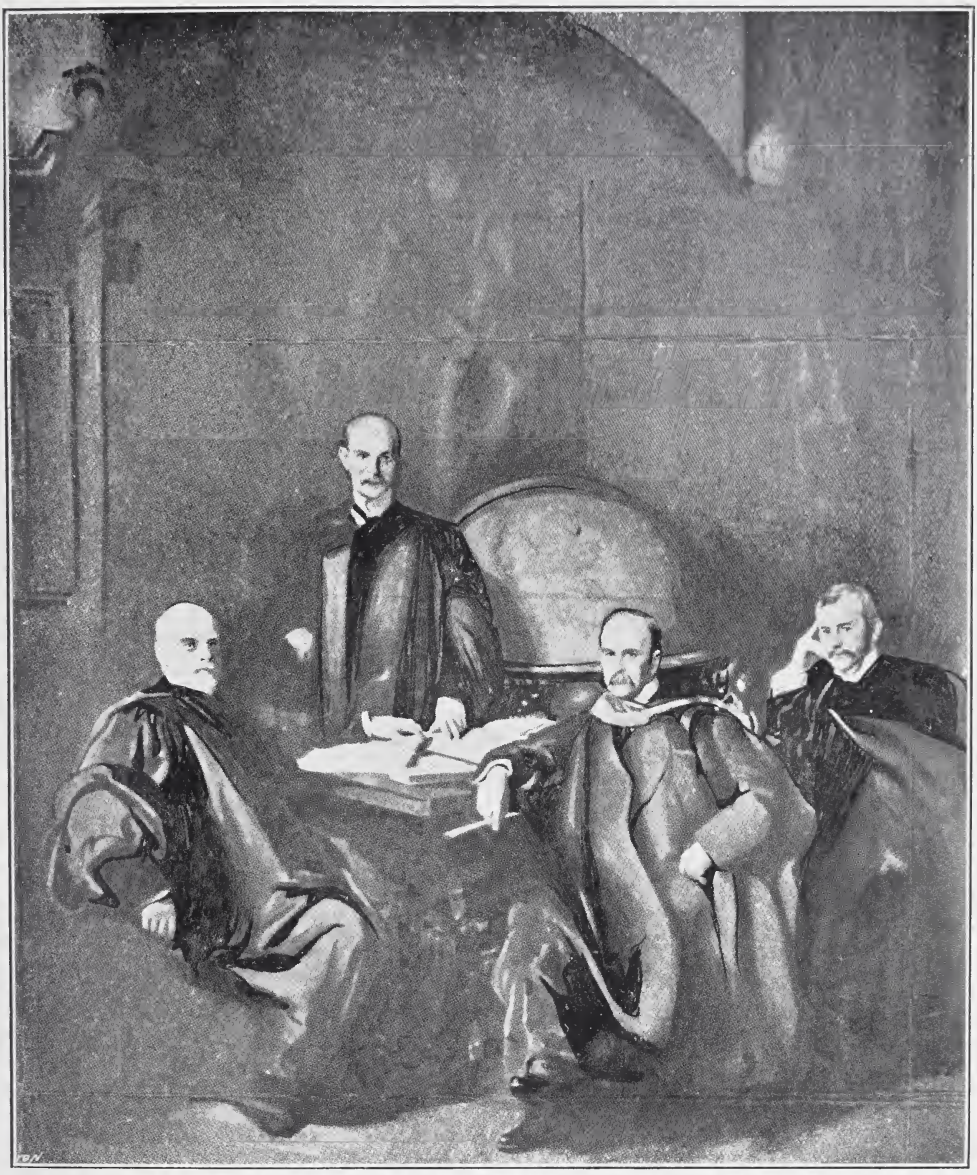
Dr. Samuel Mudd's great professional misadventure began at 4 o'clock in the morning on April 15, 1865, when he came downstairs in his night shirt to admit two men, Tyler and Tyson, the former of whom had an injured leg which he said was caused by his horse having fallen upon it. The leg was broken. Dr. Mudd set it, put the man to bed for 10 hours' rest, after which he and his companion Tyson resumed their journey on horseback. A week later Dr. Mudd learned that Tyler was John Wilkes Booth, the assassin of

President Lincoln. In another week Dr. Mudd was a prisoner on the charge of complicity in the assassination, and in September he was a convict imprisoned in Fort Jefferson on the Dry Tortugas. Here he was promoted to the carpenter shop after a severe apprenticeship in irons. Two years later, in September, 1867, the fearful epidemic of yellow fever being under way, and the medical officer of the post having died, Dr. Mudd left the work bench and the commandant left his office, at the same hour of the morning, each looking for the other and on the same errand. Their business was practically concluded before they actually met. A third person was able to assure the commandant that Dr. Mudd would undertake the duties of post physician. He stopped the removal of the sick to another island, and insisted that they should be cared for at the fort and should be covered with blankets instead of sheets. He had good luck with his patients. There were 15 or 16 new ones every day. In a short time he was superseded by another medical man from Key West, but continued his arduous labors until attacked by the fever himself. It was soon over, and he was at work again among the sick until but 10 men appeared at rollcall and but 30 all told were fit for duty, not an officer among them. During this period Dr. Mudd's mail was received with the seals unbroken, and he wrote letters, a few. When the susceptibility of the population was exhausted the epidemic ceased. Dr. Mudd could have left the island a dozen times during the height of the epidemic.

He went back into irons and washed down the bastions. Refusal to do this work was punishable by death on the spot. This was proved by those who tried it. His mail, both coming and going, had to pass the curious scrutiny of a provost marshal. Be careful how you ask a veteran of those times what a provost marshal was. The title is ephemeral, but its memory is everlasting. Few manifestations of pain are more vivid than the blush of an ex-provost marshal.

On February 13, 1869, President Johnson pardoned Dr. Mudd, but omitted to ask the Doctor's pardon. On March 20, 1869, Dr. Mudd was received again into the bosom of his family in Prince George county. He died on January 10, 1883, aged 49 years and 21 days.

His daughter employs few words of her own in the book just published by the Neale Publishing Co., and her father's memory will be the better honored for her reticence. The greater part of the book is made up of letters written by Dr. Mudd—homely things, most of them addressed to his wife. The artless flow of this correspondence makes an impression so strong that the argument of General Ewing, forcible as it is, and convincing as it must have been to fair minds among those who heard it, seems insignificant by comparison. The trial and punishment of Dr. Mudd is an unique chapter in the annals of the medical profession. The times demanded victims, and a Maryland country doctor, of good antecedents and education, unwittingly qualified himself, by a humane act, for the propitiatory sacrifice to an insane public opinion. What is more important, and especially gratifying, to physicians, he bore his part throughout in the manliest way. That Dr. Mudd had met Booth twice and failed to recognize him in the bearded and crippled man, Tyler, who awakened him at 4 in the morning on April 15, 1865, is the whole ground of fact upon which Dr. Mudd was convicted. The profession of that day lost him; the profession of this day should recover him.



Painted by John Singer Sargent. *Courtesy of Baltimore American.*

DR. WILLIAM H. WELCH, DR. WILLIAM S. HALSTED, DR. WILLIAM OSLER AND DR. HOWARD A. KELLY.

Professors of Pathology, of Surgery, of Medicine and of Gynecology from the opening of the Medical School of the Johns Hopkins University in 1893 until the painting of this portrait in 1905, to whose eminence as investigators and teachers is due in great measure its fame as a School of Scientific Medicine.

Presented by
MARY ELIZABETH GARRETT
to the
JOHNS HOPKINS UNIVERSITY

Painted by Sargent. *Courtesy of Current Literature Publishing Company.*

THE CHILDREN OF ISRAEL BENEATH THE YOKE OF THEIR OPPRESSORS—BOSTON LIBRARY

"The panels are full of dignity and beauty. Their significance, both as decoration and allusion, is progressive, passing from the serene simplicity and tempered realism of the prophets through the mingling of human tragedy and symbolism in the misery of the apostate Jews, up to the bewilderment of beauty and horror in the representation of the tangle of false faiths."

PRESENTATION

"President Remsen—It gives me much pleasure to present to you, and through you to the Johns Hopkins University, this portrait group of the four great physicians and surgeons who, with the distinguished teachers they have gathered around them, have made our native city of Baltimore one of the chief places in the world for the study of scientific medicine. * * * * The wonderful success of the medical school of the university is due in great measure to their personal pre-eminence as investigators, practitioners and teachers; to their initiative in organizing and maintaining the highest standards of medical teaching, and to their devotion to the truest ideals of scientific medicine."—*Miss Garrett.*

Courtesy of Doubleday, Page & Co.

JOHN SINGER SARGENT

Son of a Physician. Born in Florence.
The Most Talented Portrait Painter in the World.

"On behalf of the trustees of the university I have much pleasure in accepting this splendid gift. * * * * It will be a reminder of the services rendered to the Medical School by the four men who are represented, and it will be an influence for good to the country at large, for, as a great work of art, it is of value, independently of all other considerations."—*President Remsen.*

DELINEATION

"How shall one describe the method of John Sargent? It reveals the alertness and versatility of the American temperament. * * * * In all his work there is a vivid meaningfulness; in his portraits, especially, an amazing suggestion of actuality. * * * * This skill of hand is at the service of a brilliant pictorial sense. * * * * And then, too, how tactful is the selection of pose, costume and accessories! With what taste he creates environment for the conception of his subject! * * * * Sargent has instinctive refinement. This man with his gift of seeing pictures, with his power of a brush that seems loaded with light rather than with pigment, with his smiting force or tender suggestiveness of expression—what might he not have done had he followed the bent of his mind, a mind stored with culture, serene and reflective."—*Coffin.*

"Duran taught Sargent, above all things, to keep his eye on the object when he was painting—to make sure of his facts. * * * But it is important to remember that the pupil had latent in his brain and hand all that the master could teach him—all, and a great deal more. It was natural for him to see clearly and draw truthfully."—*Cortissoz.*

Medical Items.

BALTIMORE.

Dr. John C. Hemmeter presented to the Medical and Chirurgical Faculty, on December 31, a life-sized marble bust of Rudolph Virchow, and made an address on "Rudolph Virchow as an Anthropologist."

The police department of Baltimore city has been very active of late in suppressing the spitting nuisance in street cars and public buildings and on the sidewalks. A large number of arrests have been made, and in nearly all the cases fines have been imposed. It is most unpleasant, but necessary, to remark that medical students are, as a class, very promiscuous spitters.

On January 3 the trustees of Johns Hopkins University formally accepted the two collections of medical books presented to the library of the Medical School by Mr. Marburg and Mr. Jenks. The gift of Mr. Marburg includes the Warrington Dispensary Library of Liverpool, numbering 944 volumes, of the 16th, 17th and 18th centuries. The gift of Mr. Jenks is the Friederich Ahlfeld Library of Marburg, Germany, and numbers 936 volumes. These are mostly on the subject of teratology. The presentation was made in the hall of the Physiological Building. Addresses were made by Dr. Wm. H. Welch and Dr. William Osler.

On January 19 Sargent's portrait group of Drs. Wm. H. Welch, Wm. S. Halsted, Howard A. Kelly and William Osler was formally presented by Miss Mary Garrett to the trustees of Johns Hopkins University. The exercises were held in McCoy Hall in the presence of a large assembly. Miss Garrett made the presentation in a short address, expressing high appreciation of the work of the four first professors of the medical faculty. President Remsen accepted the gift in the name of the trustees. Dr. Wm. H. Welch gave a highly entertaining talk on his experience as a sitter. Mr. Royal Cortissoz made an address on the art of John S. Sargent.

The Social Service Club has started a movement to call a State Conference of Charities in April. This was done at a meeting held on January 25 at the home of Dr. D. C. Gilman in Baltimore. The organizations joined in the undertaking are, besides the Social Service Club, the State Federation of Woman's Clubs, German Society, Federated Charities, Federated Jewish Charities, Board of Education, Supervisors of City Charities, Thomas Wilson Sanatorium, Maryland Association for the Prevention and Relief of Tuberculosis and the Children's Playground Association. The officers are Mr. John M. Glenn, president; secretaries, Mr. H. Wirt Steele, Mr. N. G. Grasty, Miss Spencer and Dr. Marshall L. Price; treasurer, Mr. Waldo Newcomer.

On January 22 the regents, faculties and alumni of the University of Maryland held a mass-meeting in the Germania Maennerchor Hall, the object being to prepare for the coming celebration of the University's centennial. The presiding officer was Dr. Henry M. Wilson of the class of 1850. Addresses were made by Drs. John C. Hemmeter, Hampson H. Biedler, Samuel C. Chew, F. J. S. Gorgas and Charles Caspari, Jr., on the parts of the faculties of medicine, dentistry and pharmacy and of the alumni. Hon. John P. Poe made an address on the part of the faculty of law, and Dr. Thomas Fell on the part of the School of Arts and Sciences. The endowment fund was increased during the evening by subscriptions amounting to $7000.

MARYLAND.

Late in December Dr. Simpers, health officer for Kent county, reported one case of smallpox in Sandy Bottom, and the diagnosis was confirmed by the State Board of Health. This case was said to have originated from an earlier case, that of a colored schoolteacher who passed through his attack without medical attendance. He attended to his school duties while in the eruptive stage. In January other cases were discovered in the neighborhood of Edesville and Rock Hall. These cases had been diagnosed by two local physicians as cases of chicken-pox. At the request of the county health officer the State Board of Health made an investigation. Six cases of smallpox were seen, two doubtful cases and a considerable number of convalescents, mostly negroes, who had probably passed through smallpox within the preceding three months. Dr. S. Wickes Merritt was appointed by the county Board of Health as special medical officer for the smallpox outbreak. A number of citizens of Rock Hall, feeling their community slandered by the information that smallpox was present in the neighborhood, published a signed statement in the Baltimore *Sun*, giving reasons for their belief that there was no smallpox in their neigh-

borhood, but admitting that an epidemic of chicken-pox had been in progress for some months. The State Board of Health thereupon caused the steamboat service to Rock Hall to be suspended. Among the signers of the manifesto were a justice of the peace, the postmaster of Rock Hall and Dr. Beall. Dr. Beall was active in vaccinating the people before and after having signed the manifesto. He had also accompanied the representative of the State Board of Health, visiting a number of houses, and concurring in the diagnosis of smallpox.

GENERAL.

THE typhoid mortality of Philadelphia was quite heavy in 1906, about 75 per 100,000.

PITTSBURG is said to have more than 1000 cases of typhoid fever. A good situation for January.

DR. W. W. KEEN has resigned as professor of surgery in Jefferson Medical College, Philadelphia, and has been elected professor emeritus. This action comes after 27 years of active services which have brought great distinction to the college as well as to Dr. Keen.

THE St. Louis *Medical Review* for January 5 publishes as a supplement a fine half-tone reproduction of the portrait of Lorenz Heister, belonging to the Surgeon-General's Library in Washington. To the same number Dr. F. J. Lutz contributes an article on the work of Heister, whom he considers the founder of scientific surgery in Germany.

PITTSBURG firemen were exposed to an unfamiliar danger recently when fire broke out in the Mercy Hospital. An explosion of chemicals broke some culture tubes in the bacteriological laboratory and scattered their contents over the walls and floor. Disinfecting solutions were sprinkled about before the firemen were allowed to enter the laboratory, and the firemen so exposed were placed under medical observation for a period after the exposure.

THE Montefiore Home for Consumptives, New York, recently had a narrow escape from destruction by fire. A pile of clothing in one of the dormitories had been saturated with coal oil and set on fire. Fortunately the blaze was discovered and extinguished before much damage was done. Four porters, just discharged by the hospital authorities, were arrested as the probable authors of the crime.

PHILADELPHIA'S death rate for 1906 was 18.63 per 1000, considerably higher than that of 1905. If the death rate continues at 18.5 or higher, the truly businesslike way to reduce it is to count the people and get a bigger divisor. It is easier to do that than to prevent some of the deaths and so get a smaller dividend. If one cannot count the living more than once, the next best plan is to count the dead less than once. This also is a handier method than that of saving lives. The methods can be combined, but it is imprudent.

THE Woman's Medical Association of New York held a memorial meeting on January 4 in honor of the late Dr. Mary Putnam Jacobi. The Association has undertaken to raise a fund of $25,000 for the purpose of establishing a Mary Putnam Jacobi fellowship in medicine. The income is to be used to enable a woman to pursue the study of medicine. The speakers at the meeting were Dr. William Osler, Dr. Elizabeth M. Cushier, Mrs. Florence Kelley, Dr. Felix Adler, Dr. Charles L. Dana and Mr. Richard Watson Gilder.

PHYSICIANS who have experience with the injuries which occur in jostling crowds will be interested in a recent decision of the Supreme Court of Massachusetts. Suit was brought against a suburban railway company on account of an injury sustained in a station by being thrown down in the crowd. The lower court gave a verdict in favor of the plaintiff. This judgment was sustained by the Supreme Bench, thus establishing the liability of a transportation company under such conditions.

DISCOURAGED by the difficulty of convicting persons accused of criminal abortion, the New York District Attorney's office has tried the experiment of charging such offenders under the nuisance law. A midwife was tried recently under the code provisions relating to common nuisances, and was sentenced to a fine of $500 and a year's imprisonment. A witness who had been employed in the prisoner's house testified that in three months 50 women had been operated on, and one had died. By this procedure the State is not restricted to the very precise line of inquiry laid down for capital proceedings, and can reveal the general character of the accused person's practice.

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SUGGESTIONS FOR THE REORGANIZATION OF HOSPITAL OUT-PATIENT DEPARTMENTS, WITH SPECIAL REFERENCE TO THE IMPROVEMENT OF TREATMENT.

By Richard C. Cabot, M.D.,
Boston.

READ BY INVITATION BEFORE THE MARYLAND MEDICAL SOCIETY, DEC. 4, 1906.

I. Out-Patient Work Usually Slipshod, Yet Public.

Out-patient departments are, as a rule, neglected. There are several reasons for this:

(a) A position as out-patient physician is taken chiefly as a stepping-stone to something higher, and treated, as stepping-stones usually are, cursorily, full attention being directed elsewhere ahead.

(b) As a feeder for hospital wards the dispensary demands but a preliminary examination and makeshift treatment for cases which will soon be more thoroughly dealt with in the wards, and this hasty and makeshift character naturally extends to the work done for the much larger number of patients who do not enter the wards at all.

(c) In most out-patient clinics the number of patients is so large and the number of physicians and assistants so small that no good work can possibly be done within the time limits prescribed by the other and more lucrative business to which physicians must also attend.

(d) Very often I have found out-patient physicians discouraged because their patients come to the hospital but once, and are seen for so short a time that no thorough diagnosis is possible.

(e) If we inveigh against these slipshod methods we are met with "what can they expect? Time is money. They pay nothing,

and are too ignorant to profit by careful advice. The conditions and the patients being such as they are, our work is good enough." This is rarely said, but usually acted on. Yet we must remember that dispensary work is essentially *public work,* and that it is sure sooner or later to be affected by—

II. The Modern Conception of Public Work.

As long as work done without pay is thought of primarily as "charity"—i. e., as something which it is to a man's credit to do at all—we readily pardon its poor quality. With the gradual transformation of our habits of thought, hospital work has now begun to be thought of not as "charity," but as *public work*—work called for by the public, and therefore demanding the best we have to give. A private road, a private way, is "dangerous passing." Only the public roads are guaranteed to be of standard quality. We now demand that public education shall be equal to the best anywhere attainable, and in public institutions for the feeble-minded, the epileptic or the tuberculous the standard is sometimes higher than that easily obtainable in private enterprises. When we want standard quality of vaccine or of diphtheria antitoxin, we turn (at any rate in Massachusetts) to our State Board of Health.

Such is the tendency in many fields of work, and the tendency is beginning to make itself felt in one of the last strongholds of the old regime. Beginning with perfection of equipment in the surgical operating-rooms of modern hospitals, the reform movement is spreading via the wards to that forgotten corner of the hospital, the dispensary. Reform of record systems has begun, though I will venture to say that there are not a dozen dispensaries in the country where the records are properly kept, used, indexed and filed. The number and quality of assistants and the amount of space for examining rooms is increasing in many dispensaries. But despite these reforms, I suppose no one would today maintain that the public work done by physicians in dispensaries is anywhere as good as the private work they do in their offices for their private patients.

Why should the public tolerate this? I see no good reason. The public insists that the public work done by the lawyer as attorney-general or district attorney shall be up to the standard of private law practice. If we had reason to believe that State and city laboratories did other than the best work in their examinations of diphtheria cultures, sputa and blood, we, the public, would be up in arms—indignant. Why should not dispensary work be tried by the same standards? Primarily, I believe, because the public does not pay for dispensary work. The public pays for the buildings and equipment, but the physicians do the work for nothing, and such work is usually poor. Here and there a hospital or one man in a hospital will keep up to professional standards, although he is doing his work as a minor item in his life, but in the long run not often.

The only paid dispensary work that I know of in this country

is that done by the Tuberculosis Dispensary established by the Board of Health in New York city, and by the nurses who work in connection with the Children's Hospital, Mt. Sinai Hospital and Berkeley Infirmary in Boston and Vanderbilt Clinic, Bellevue, Presbyterian and other New York hospitals. When the dispensary is used largely for teaching purposes, as at Harvard, Cornell and Johns Hopkins, we get some good work done, because the paid teachers are part of the dispensary staff.

I have no hesitation in saying that if the good of the patient is what we chiefly have at heart, the public medical work of our dispensaries must be done in part by competent, well-paid officials, as the work of public diagnosis laboratories now is.

Volunteer assistants and supervisory boards may well be unpaid, but there must be a permanent corps of men whose chief business in life is dispensary work if that work is to be well done. Men to whom it is a "side show," and who do it "by the way," may do it well, but in the long run will never do it as well as it can be done.

III. Abolition of Hurry and Makeshift Possible Only by Paying Those in Charge.

Firmly fixed in most dispensaries of this country is the tradition of hurry. Everything must be done fast, not only the fetching and carrying, the clerical work and all the low-grade jobs (which ought to be done swiftly), but also the examinations and the treatment, which can rarely be done at the rate prescribed by tradition in most dispensaries, without slovenliness, errors and failures to help the patient.

As dispensaries are now organized, hurry and makeshift are indispensable, for if every patient were properly questioned, examined and advised, an average-sized clinic would take all day. But it cannot take all day, for the men in charge must earn their living, which means that they must get away from the dispensary in an hour or two, at most three, either leaving the bulk of the clinic to assistants and students, or rushing through the cases at a speed that makes accuracy and efficiency quite impossible.

Why not have more physicians, so that each need treat but a few patients a day? Because the ablest physicians won't take the job on those terms. In order to make it worth while for an able (and therefore busy) physician to give time to dispensary work, you must allow him the privilege of "skimming the cream" off the clinic; that is, of controlling and rushing through a relatively large number of patients for the sake of the few "interesting cases" to be found in the bunch. The physician takes his pay in this form. He uses a dispensary clinic to furnish interesting cases for teaching or for scientific study. This is usually very good for the small minority of interesting cases, and very bad for the great majority of uninteresting ones, which are served in a slovenly or perfunctory way.

Is there any good reason in the nature of public medicine why an examination of sputa should be done well at the public labora-

tory, while an examination of the chest is done badly (as most are) at the public dispensary? Why should we not demand standard quality of work in the one case as much as in the other? Both are free and public. The one is good, the other bad. The free public examination of sputa is fully as well done as it is in our office practice. What good reason can be adduced for treating a dispensary patient any less well than an office patient?

At the Massachusetts General Hospital we have succeeded in raising the standard of diagnostic work in the dispensary nearly as high as it is in private office practice, but in treatment we are still woefully far behind what we ought to be, for it is in treatment that our system of carefully supervised student work breaks down.

IV. Three Eras in the Evolution of Dispensary Therapeutics at the Massachusetts General Hospital.

1. The era of wholesale drugging.
2. The tractarian or ritualistic era.
3. The beginning of better things.

1. *The Era of Wholesale Drugging.*—When treatment was confined chiefly to drug treatment, and diagnosis went no further than symptoms, it was not difficult for a dispensary physician to "run off" 40 or 50 cases in a couple of hours. To tear off and hand out printed prescriptions for "Sol. 0" or "Mist. 13" is easy and quick, and it pleases many patients much better than the present lengthy examinations and tedious waiting for a talk with the doctor at the end. The patient wants to get back to his home or his work as quickly as he can, and so long as he is kindly treated—the briefer the preliminaries of all kinds before the coveted prescription is handed out—the better he likes it. Thus pressure from without and pressure from within (the doctor's need to get away and attend to his practice) combine *to make the dispensary* what its name suggests—chiefly *an enlarged apothecary shop*, a place for giving and getting medicine.

This tendency to give drugs (either as curative, palliative or placebo) to almost every patient and at every visit used to produce a very comfortable revenue for those out-patient departments which dispense their own drugs. Of late, however, there is with us a noticeable abatement of the flood of drugs pouring out of the dispensary and into the community. The following figures show this:

Massachusetts General Hospital—Out-Patients.

Year.	Number of visits.	Number of prescriptions.	Visits exceed prescriptions by—
1902	88,868	58,177	30,691
1903	95,728	55,285	40,443
1904	106,175	53,321	52,854
1905	110,631	49,793	60,838

That this change is in line with the best tendencies of modern medicine I think few will deny. The change would be much more marked if the pernicious habit of placebo-giving could be checked.

Only a small proportion of the drugs prescribed at the Massachusetts General Hospital (and I suppose at other hospitals) are given because of any confidence in their pharmacological action. Most of them are given because of the well-founded belief that "we must give something," and because, with the present organization of our out-patient departments, that "something" has to be a drug. For proper instruction in hygiene and dietetics, for the proper application of mechanical, thermic, hydrotherapeutic and psychotherapeutic remedies, for the proper investigation and removal of domestic, social, industrial, mental and moral causes of illness—for all these most important methods of palliation and cure our dispensaries are by their organization and plan unfitted. Yet the sense that we must "give the patient something," combined with a growing discontent with pure drug therapy, brought us to—

2. *The Tractarian or Ritualistic Era.*—In recent years printed directions, describing the proper methods of caring for the stomach, the bowels and the lungs, have been distributed like tracts and in great numbers from many dispensaries. With these go printed diet slips suitable for constipation, dyspepsia or diabetes. *Here we have the form, but not the substance of good treatment.* The patient needs advice and direction. We give it to him in print, in form and theory, not in fact. We go through the forms of up-to-date therapeutics admirably as any ritualist, but the whole thing is hollow—nothing comes of it. A sharp change in a person's habits of eating and drinking, sleeping, thinking, working is what the tract demands. But we know perfectly well, if we reflect or observe, that no such change is brought about in any such easy fashion. The patient takes the tract, perhaps keeps it, possibly reads it, conceivably understands it, probably loses it, certainly does not act upon it. As I have myself written several of these tracts and given out several thousands of them, I do not believe I am in any way prejudiced against them. They have a distinct though quite limited usefulness if given together with careful verbal instructions in which the general rules are fitted and shaped to the needs and peculiarities of each individual. But even if this is done, they have to be followed up usually by a series of visits at the patient's home. We must see that the treatment is carried out.

3. *The Beginning of Better Things.*—(a) We are beginning to develop for medical cases forms of treatment *which can be carried out* (as surgery is) *on the spot.* This is, I think, a great advance. To be sure that a portion at least of the treatment which you advise is regularly and properly applied is the first step towards solid ground. Thus in the neurological department of the Massachusetts General Hospital Dispensary, Freund's psycho-analysis, Frankel's re-educational treatment, and in some cases massage, are given. The Zander apparatus for active and passive exercises, for mechanical massage and for vibration is usued largely by out-patients, and the hydrotherapeutic room now being fitted up in the

dispensary will doubtless be of benefit to dispensary cases as well as to ward patients. All these methods of treatment enable us to do something of real value for patients to whom we formerly gave placeboes. We surely "must give something" to all patients, and the most hopeful fact about the present situation is that we have begun to make that "something" more *varied* in accordance with the varied needs of the patients. Having paid professionals to run our Zander-room and our hydrotherapeutic-room, we no longer have to rely on the only treatment that can be given in a hurry, namely, the drug treatment. Time and pains and a thorough individualizing study can be given by these paid therapeutic experts to the needs of each case. *Treatment can be given on the spot and its results followed.* That means business. It lacks, however, the knowledge only to be gained by following up the patient in his home.

V. Social Work and Visiting Nurses as Necessary Elements in Good Treatment.

To find the cause of disease, and remove it when possible, is the first principle of all rational therapeutics. But if we are in earnest in this matter, and do not rest content with large phrases, we may have to go pretty far afield in pursuit of this "cause." When malnutrition is due to poor appetite and poor sleep, and when these, in turn, appear to result from worry, our pledge to be thorough, to go to the bottom of our patient's malady, find its cause and root it out, compels us to undertake through others (nurses or social workers) investigations for which we as dispensary physicians have neither time nor training. Especially is this true in the so-called "functional diseases." In cases of malaria or tapeworm we easily find and remove the causes. There is no need of subtle social investigation nor of much following up at home. A drug will kill the parasite. How often we wish that in the rest of therapeutics we had already attained such precision! But at present there appears in any dispensary a considerable proportion of "functional" cases, in which a knowledge of the patient's habits, of his economic, domestic and social conditions, is essential to any adequate understanding or competent management.

In the table below, I have collected the number of cases of each of the commoner diseases treated at our dispensary in 1904.

I have grouped on the left the "organic" and on the right "functional" cases as I understand those terms. Under the heading of "functional" I have put the cases in which, in my opinion, the symptoms are to be ameliorated chiefly by a change in the patient's habits and by the correction of hygienic faults. I imagine that most physicians would agree to the items here grouped together, with the possible exception of uterine displacements. I will not stop now to argue the case on this point. Including uterine displacements, the "functional" cases make up 41 per cent. of all the medical cases seen at the dispensary. With the uterine displacements excluded, 37 per cent. are functional.

Massachusetts General Hospital Dispensary—Medical Department.

"Organic" Disease.		*"Functional" Disease.*	
Tuberculosis	461	Constipation	651
Organic heart disease	464	Dyspepsia and nervous dyspepsia	378
Bronchitis	373	"Debility"	306
Arthritis (all types)	182	Uterine misplacements	258
Arterio-sclerosis	156	Neurasthenia	209
Pleurisy	134	Apprehension	144
Nephritis	122	Headache and other pains without known cause	137
Cancer (chiefly of stomach or uterus)	96	Hyperchlorhydria	95
Asthma	72	Alcoholism	84
Anemia	69	Enuresis	61
Syphilis	63	Gastroptosis	47
Appendicitis	60	Cardiac neurosis	43
Lumbago	59		
Gallstones	54		
Colitis	52		
Malaria	47		
Emphysema	43		
Diabetes	41		
Typhoid	37		
Neuritis	23		
Cirrhosis	19		
Angina pectoris	18		
Aneurism	16		
Total	2561	Total	1813
	or 59%		or 41%

Now for this 37 per cent I think it will be generally agreed that what we chiefly need is a correction of faulty habits and the practice of what is *for each person* the best attainable hygiene. How are we to obtain these reforms? They are not easily or quickly won.

(a) Sometimes careful instruction both at the hospital and in the home suffices.

(b) Sometimes the patient must be removed from the friction and worry of home conditions and started afresh elsewhere (vacation, change of scene, convalescent home).

(c) Sometimes he must be helped to get the necessary but somewhat expensive means to recovery—a set of false teeth, an abdominal support, a nourishing diet, a vacation, a good friend.

For none of these needs is our ordinary out-patient staff sufficient. The doctors have not the time or the training. But there are in the community many societies, institutions and persons whose aid can be enlisted if someone will attend to the connecting links. We ought no longer to neglect these offers from the community outside the hospital walls. We can no longer ignore the absence of connecting links and commend the patient to do what we know he won't or can't do.

In the out-patient department of the Massachusetts General Hospital (and I suppose in most other hospitals) there occurs many times each year a scene not unlike that described in "Alice in Wonderland:"

"'Have some wine,' said the Hatter.

" 'I don't see any wine,' said Alice.
" 'There isn't any," said the Hatter."

Without any sense of the humor and pathos of the situation we say (in substance) to many patients: "Take a vacation," or "Get a new job," "Change your job," or "Get a truss." There is none in sight and no means of getting any. What do we do then? We pass cheerfully to the next patient.

This is one of the gaps which the social workers have tried to fill at the Massachusetts General Hospital. Believing that when a hospital undertakes the care of a patient it ought to *do it*, and not be content with going through the forms of doing it, we have tried to fill the gap between good intentions and their fulfilment. Simply to hand a phthisical patient printed directions for the care of his health is to go through the forms of treatment without actually doing anything for him. To tell him to rest out of doors, to sleep out of doors, and to eat twice as much as usual produces no appreciable change in his mode of life. To follow him up, show him how to do it, and see that he actually does it is the only business-like way of treating his disease.

T. H., a young unmarried Jewess, was for two years a pitiable figure in the out-patient department and in the clinic. She had Raynaud's disease, a painful affection of the hands, entirely disabling her in cold weather, while in summer she was a tolerably comfortable and efficient domestic. The treatment given her had been quite unavailing, for what she needed was a warm winter climate. Our head social worker, Miss Pelton (to whom the case was referred from the nerve department), secured a place for her with a personal friend in Florida, begging some clothes for her, secured $8 from the Federation of Jewish Charities, $10 from the nerve department, and, with the help of the American Invalid Aid Society, bought her ticket and put her aboard the train for Florida in the company of a friend who was making the same journey. In the warm climate the disease quickly disappeared.

What we did was (with the help and advice of existing benevolent agencies) to fill the gap between good intentions and their fulfilment—a gap which is becoming more and more difficult for the out-patient physician unaided to fill.

When drugs and local applications were our favorite weapons in the treatment of disease a physician with a team of lively assistants could easily "run off" his 50 or 60 cases in a morning. But since the medical profession has come to believe that the great common diseases—consumption, epilepsy, dyspepsia, neurasthenia—are to be benefited chiefly by a radical change in the patient's habits and surroundings, a change of diet, a change of work, a long period of rest in the open air, it has become impossible for an out-patient physician to "run off" his clinic in the chain-lightning fashion of old days.

A woman is found to have diabetes. Medicine will not help her much; diet will help, but it is useless to hand her out a diet-list without finding out whether she can get at her boarding-house

any such diet as we recommend. It turns out that she cannot, that there is no boarding-house for diabetics, and that she has no money to spend on specially-selected diets. Shall we simply pass to the next case and let the woman's disease run on to its fatal termination unimpeded? The physician in charge has no time to investigate her case or to discover what resources, if any, the city of Boston contains for supplying her need. He cannot look up the question whether relatives, friends, church or benefit societies can be gotten to lend a hand. But he cannot turn his back upon the woman and let her die without an attempt to check the disease. He needs the help of social workers to *make his treatment effective.*

Here is a woman who ought to come into the hospital for an operation. The proper treatment is easily seen and easily recommended, but she cannot take it because there seems to be no one to look after her children while she is away from home. She cannot leave them alone, and so she sadly but firmly refuses to do the only thing that will cure her. Sometimes we are provoked and scold her. "Why will you persist," we say, "in refusing to do the obviously right thing?" "But how about the children?" she says. Again the alternative presents itself: Can the physician or hospital superintendent spend time in hunting up someone to look after the children in their mother's absence? Of course not. Physicians have neither the time nor the training for it. They seldom know enough even to refer the case to the proper charitable agency, and the house officer (who usually has most of the dealings with the case) knows even less of social work. Shall we then simply turn the patient away? I have seen many cases so turned away without help or hope. In 1902 I knew an out-patient coming from a distant town (Petersham) who waited three years with a painful and exhausting malady because no way could be found to shift the home burdens temporaily onto other shoulders. Yet the trouble was curable by a simple operation, and in the end was thus cured.

To order for one patient a diet which he cannot possibly procure; for the next, a vacation which he is too poor to take; to forbid the third to worry when the necessary cause of worry remains unchanged; to give the fourth directions for an outdoor life which you are morally certain he won't carry out: to try to teach the fifth (a Jewish mother) how to modify milk for her baby when she understands perhaps half what you say and forgets most of that half—this makes a morning's work not very satisfactory in the retrospect to anybody, and hardly more useful than the old-fashioned wholesale drugging.

It was to fill just such needs as we have suggested that there was organized in October, 1905, a small force of social workers to attend to any cases which the out-patient physicians might see fit to send them. In the year ending October 1, 1906, 683 cases were so referred to us by the out-patient staff and by the assistant superintendents of the hospital.

The general nature of these cases is indicated by the following divisions into which the work seems to fall as time goes on:

Main Divisions of the Work.

1. *Tuberculosis;* the proper disposition of cases in hospitals, classes, etc.
2. *Hygiene teaching* for some of the multitude of cases who need it.
3. *Infant feeding;* demonstrations and directions to mothers.
4. *Vacations and country outings* for those who need them as part of their treatment.
5. *The care of unmarried girls, pregnant, morally exposed, feeble-minded.*
6. *Help for patients needing work or a change of work.*
7. *Assistance to patients needing treatment after discharge from the hospital wards.*

On the details of this work I have no space to dwell in this paper. They are carried out by a staff of two paid social workers on full time and 15 or 20 volunteer assistants. The only other subject of which I wish to speak is

The Class System in Dispensary Work.

Tuberculosis and the diseases of infancy are the only maladies which now get first-class treatment in a number of large dispensaries. As regards these diseases we have come to realize the simple fact that a great deal of painstaking, time-consuming attention to the details of each patient's case, both at the dispensary and (through nurses) in the home, is the only way to accomplish anything in treatment.

But it is just as true of every other disease, and unless we are ready to do a great deal more than we are doing for the neurasthenias, dyspepsias, varicose ulcers, etc., which throng our dispensaries *it is not worth while to do so much.* Such elaborate and careful diagnosis, so much talking and prescription writing is a waste of time *unless it is followed up.*

There should be a diabetic "class," a "class" for treatment of cardiac diseases, for neurasthenic cases, epileptics, constipation, and each of the common diseases. The essentials in such a "class" are:

(a) A nurse to follow up the cases at home and see that the doctor's advice is followed.

(b) A room or corner where the physician and his patients can be undisturbed, and where books, circulars, pictures and apparatus bearing on the disease in question can be accumulated.

(c) A reasonably energetic and intelligent physician who, for a few weeks or months, will devote himself to one therapeutic problem.

It would rarely be desirable, I suppose, for one man to remain in charge of one "class" more than a few months, but by exchanging "classes" a group of physicians could then obtain valuable therapeutic experience.

SUMMARY AND CONCLUSIONS.

1. Dispensary work is part of public-health work, and should be done as well as are the examinations made at State and municipal laboratories.

2. To attend to the mass of details on which good treatment depends a nucleus of permanent paid employes is necessary. This paid staff should consist at present of nurses trained for the purpose.

3. These paid employes should understand the doctor's directions and see that they are carried out in the patient's home, reporting back to the physician any data concerning the domestic and social conditions which bear on the diagnosis and treatment of the cases.

4. Either through these nurses or through social workers on hand daily at the dispensary the hospital should obtain for its patients the full benefit of any resources—moral, educational and financial—which the community affords. This help is especially important in the "functional" cases, which make up over one-third of the medical out-patient clinics.

5. Through these means and by the development of mechanical, psychical and hydro therapeutics our dispensaries can be freed from the twin abuses which now limit their therapeutic usefulness:

(a) Hurry and consequent makeshift.

(b) Wholesale drugging.

Reference.—See *First Annual Report of Social Work and Applied Therapeutics at the Massachusetts General Hospital*, 1905-06, to be had on application to the writer at 190 Marlboro street, Boston.

THE DANGER OF SENDING CONSUMPTIVES TO THE COUNTRY.

By Ellen N. La Motte,

Tuberculosis Nurse of the Instructive Visiting Nurse Association of Baltimore.

WITH the knowledge that tuberculosis is a curable disease has arisen, as far as the public is concerned, a very imperfect understanding of the class of cases that may be cured. The public mind is very generally imbued with the belief that fresh air is the remedy for the disease, and that country air is much more valuable than any other in bringing about the desired cure. The physical condition of the patient is not recognized as a factor in the situation. Advanced and hopeless cases are usually the ones that are sent from the cities and, in many instances, through the efforts of some charitable agency. It is not as if sending these patients away meant their ultimate recovery. It does not, for in most instances the patients could not gain admission to a sanitarium, being in too advanced a stage for cure. It means simply that the lives of these

patients are somewhat prolonged, and that in so doing the disease is spread among the ignorant and helpless people of remote country districts.

The history of a tuberculous patient in Baltimore is about as follows: He usually consults some physician or visits a dispensary once or twice a month, and is given such medical treatment as is necessary. The tuberculosis nurse also visits him two or three times a month, keeps him provided with sputum cups, etc., instructs him in the care of his health, and, above all, teaches the family the dangerous character of the disease and how to avoid infection. When he dies or moves his house is fumigated and everything possible is done to prevent the spread of tuberculosis. It is a noticeable fact that, however careless and indifferent the patient himself may be, his family is nearly always fully alive to the danger, and the more careless the patient the greater the efforts of the family to protect themselves. Now when a patient is advised to leave his home and go to the country he is taken away from all these influences and no one is responsible for him. He has no one to direct him, and he forgets in a day all that he has been taught. He knows that he was sent away for "country air," and if he can get that air while huddled over a stove, so much the better. His appetite is poor, and there is no one to insist upon his eating; moreover, the quality of food among country people is often bad. In one instance a young woman who had been sent away and whose board had been paid for weeks by a charitable agency reported that she could get no eggs, as the hens had stopped laying, and had only a quart of milk every other day. She asked if she could not come back to the city, where she could get more to eat. Cases like this are frequent.

As for the patient taking any precaution against the spread of his disease, if he takes any sputum cups with him they are soon used up. The chances are, however, that he took none, for when a consumptive is not careless he is sensitive, and once away from a family opinion that demands protection he abandons all efforts in that direction. He thus becomes a constant source of danger to the people he is in contact with, and it is impossible for him to derive much benefit from country residence. He often returns to town after a stay of weeks or months much worse than when he went away. Out of 55 cases under observation in the last 18 months only 2 were really benefited by this stay in the country; 13 were temporarily improved, but lost it all within a few weeks; 32 returned to the city much worse than when they went away, and 8 died while in the country.

So much for the benefit derived by the patient. The danger to the community must now be considered. As a result of sending these 55 cases to the country it is probable that 55 centers of infection were created, and it is doubtful if any of these infected houses were afterwards fumigated or cleaned with a view to making them harmless. It has been, of course, impossible to follow the results in all these households—little country farmhouses in re-

mote counties—but doubtless some of them were as appalling as in the two instances that have recently come to our knowledge. One of these was the case of a consumptive sent from Baltimore to a little farmhouse in Virginia, and *three members of that country household contracted tuberculosis from him.* The original patient died, one of the secondary cases died, and the other two have but a few months to live. The other case is of a woman who had been under the surveillance of the tuberculosis nurse for some months. While in the city the nurse saw to it that the patient used her sputum cups regularly and slept in a room to herself. This patient, who had been sick about two years, was finally sent to the country. She had no supplies, and she and her child of five occupied the same bed while in the country. At the end of five months she returned to Baltimore almost in a dying condition, and it was found that her child had contracted tuberculosis.

This indiscriminate sending of patients to the country is a very serious matter. It is of little value to the consumptive, but of grave danger to the helpless and ignorant household where he is quartered. If he cannot be admitted to a sanitarium, he should be watched over at home, where his menace to the community may be lessened. However sympathetic we may be, sentiment should give way to facts, and the facts show that the consumptive has not (by the very nature of his disease) sufficient moral courage to undertake the rigorous open-air treatment alone. By ordering him to the country we shift the responsibility and so ease our consciences, but we do not help the patient. We merely spread the disease. Until public sentiment demands hospital facilities for these patients we should keep them in their homes. For advanced cases we need hospitals, not farmhouses.

Books Received.

Receipt is acknowledged of the following books:

The Practitioner's Visiting List. Philadelphia: Lea Bros. & Co. 1907. $1.25 net.

The Diseases of the Nose, Throat and Ear. By Charles Prevost Grayson, A.M., M.D. Second edition, revised and enlarged. Philadelphia: Lea Bros. & Co. 1906.

Transactions of the Third Annual Conference of State and Territorial Health Officers with the United States Public Health and Marine Hospital Service, May 15, 1905. Washington: Government Printing Office. 1906.

Transactions of the Fourth Annual Conference of State and Territorial Health Officers with the United States Public Health and Marine Hospital Service, May 23, 1906. Washington: Government Printing Office. 1906.

Report of the Surgeon-General U. S. Navy, Chief of the Bureau of Medicine and Surgery, of the Secretary of the Navy, 1906. Washington: Government Printing Office. 1906.

Pulmonary Tuberculosis. By Albert Philip Francine, A.M. (Harv.), M.D. (U. of P.) Philadelphia: J. P. Lippincott Company.

Diseases of Children: A Manual for Students and Practitioners. By George M. Tuttle, M.D. Philadelphia: Lea Bros. & Co.

Transactions of the American Dermatological Association at the Twenty-Ninth Annual Meeting, Held in New York December 28-30, 1905. Official Report of the Proceedings by Chas. J. White, M.D., Secretary.

A Treatise on Orthopedic Surgery. By Royal Whitman, M.D. Third edition, revised and enlarged. Philadelphia: Lea Bros. & Co. 1907.

Harvey Lectures. Delivered under the auspices of the Harvey Society, 1905-1906. Philadelphia: J. B. Lippincott Company. 1906.

International Clinics. Edited by A. O. J. Kelly, A.M., M.D. Volume IV. Sixteenth Series. 1906. Philadelphia: J. B. Lippincott Company. 1906.

Woman in Girlhood—Wifehood—Motherhood: Her Responsibilities and Her Duties at All Periods of Life. By Meyer Solise-Cohen, A.B., M.D. With Manakin Chart. Philadelphia: John C. Winston Company. Price, $2 net.

Practical Dietetics with Reference to Diet in Disease. By Alida Frances Pattee. Fourth edition. Mt. Vernon, N. Y., and 52 W. 39th street, New York: A. F. Pattee. Price, $1 net.

Transactions of the American Ophthalmological Society. Forty-Second Annual Meeting, New York City, 1906. Volume XI, Part 1. Hartford: Published by the Society. 1906.

Sixth Annual Report of the New York State Hospital for the Care of Crippled and Deformed Children for the Year Ending September 30, 1906. Publishers, J. B. Lyon Company. 1906.

The Muscles of the Eye. By Lucien Howe, M.A., M.D. Volume I—Anatomy and Physiology, Including Instruments for Testing and Methods of Measurement. New York and London: G. P. Putnam's Sons. $4.25 net. Both volumes, ordered before July 1, 1907, $7.50 net.

Golden Rules of Surgery. By Augustus Charles Bernays, A.M., M.D. (Hdlbg.), M.R.C.S. (Eng.) Publishers, C. V. Mosby Medical Book Co. 1906. Price, $2.50 net.

Golden Rules of Pediatrics. By John Zahorsky, A.B., M.D. Publishers, C. V. Mosby Medical Book Co. 1906. Price, $2.50 net.

Fourth Annual Report of the Committee on the Prevention of Tuberculosis of the Charity Organization Society of the City of New York for the Year 1905-1906.

Diseases of the Lungs. By Robert H. Babcock, A.M., M.D. First edition. Publishers, D. Appleton & Co. 1907.

Essentials of Obstetrics. By Charles Jewett, A.M., M.D., Sc.D., assisted by Harold F. Jewett, M.D. Third edition, revised and enlarged. Philadelphia: Lea Bros. & Co. 1907.

A Study of the Human Blood Vessels in Health and Disease. A Supplement to "The Origin of Disease." By Arthur V. Meigs, M.D. Philadelphia: J. B. Lippincott Company.

Annual Report of the Surgeon-General of the Public Health and Marine Hospital Service of the United States for the Fiscal Year 1906. Washington: Government Printing Office. 1907.

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Grimes, Samuel Butler, 1754 Park avenue.
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Houff, John, 15 North Monroe street.
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Howell, William H., 232 West Lanvale street.
Huck, John G., 647 West Lafayette avenue.
Hughes, Singleton Bernard, 705 George street.
Hundley, John Mason, 1009 Cathedral street.
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Iglehart, James Davidson, 211 West Lanvale street.
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McCormick, Thomas Pugh, 1421 Eutaw place.
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McDonald, William Bartholow, 1305 Linden avenue.
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Owings, Edward R., 1621 Linden avenue.
Owens, Robert Hamilton, 1625 West Lexington street.
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Pearce, Wilbur M., 1238 Greenmount avenue.
Pearce, William Herbert, 2105 North Charles street.
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Penning, Oliver Parker, 1711 St. Paul street.
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Penrose, Clement Andariese, 21 West Mt. Royal avenue.
Perry, William Brinton, 330 North Charles street.
Peterman, Harry Elmer, 114 West Franklin street.
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Pleasants, Jacob Hall, Jr., 16 West Chase street.
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Pole, Armenius Cleveland, 2038 Madison avenue.
Pollack, Flora, 112 West Mt. Royal avenue.
Pound, John C., 1302 West Lombard street.
Preston, George Jenkins, 819 North Charles street.
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Randolph, Robert Lee, 816 Park avenue.
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Rehberger, John H., 1709 Aliceanna street.
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Reik, A. J. N., 412 Cathedral street.
Reik, Henry Ottrage, 412 Cathedral street.
Reinhard, Ferdinand, 1400 Linden avenue.
Reinhardt, Otto M., 1017 South Charles street.
Requardt, William Whitall, 829 North Eutaw street.
Reuling, George, 103 West Monument street.

Reuling, Robert, 103 West Monument street.
Revell, S. T. R., 33 North Luzerne street.
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Rosenthal, Melvin Samuel, 519 North Charles street.
Rowland, James M. H., 1204 Madison avenue.
Ruhräh, John, 839 North Eutaw street.
Rushmore, Stephen, Johns Hopkins Hospital.
Russell, Elijah J., 423 North Broadway.
Russell, William Wood, 1208 Eutaw place.
Rytina, Anton George, 2204 East Monument street.
Sadtler, Charles E., 1415 Linden avenue.
Samuels, Abraham, 2003 McCulloh street.
Sandrock, William Christian, 1242 North Broadway.
Sanger, Frank Dyer, 525 North Charles street.
Savage, Moses M., 1121 East Baltimore street.
Schaefer, Otto, 951 Madison avenue.
Scheidt, Robert P. C., 1318 South Charles street.
Scholl, George Barr, 1005 West Lanvale street.
Schwatka, John Bushrod, 1003 North Broadway.
Seegar, John King B. E., 1529 Park avenue.
Seligman, Joseph Albert, 1920 Linden avenue.
Sellman, William Alfred Belt, 5 East Biddle street.
Shannon, George Conkle, 1442 Presstman street.
Shelly, Albert, 3849 Rowland avenue.
Shemwell, Joseph F., 2226 Madison avenue.
Sherwood, Mary, The Arundel.
Shull, John D., The Guilford.
Simmons, Horace Melville, 1706 Park avenue.
Simon, Charles Edmund, 1302 Madison avenue.
Simpson, George W., 1026 North Broadway.
Singewald, Albert G., 1503 East North avenue.
Singewald, Edward M., 5 North Washington street.
Slemons, Josiah Morris, 23 West Chase street.
Smith, C. Urban, 330 North Charles street.
Smith, Edward Augustus, 1605 West North avenue.
Smith, Frank Robert, 1126 Cathedral street.

Smith, Henry Lee, 2535 St. Paul street.
Smith, Joseph Tait, The Cecil, Eutaw street.
Smith, Nathan Ryno, 24 West Franklin street.
Smith, Robert Percy, 817 North Charles street.
Smith, William Henry, 3429 Chestnut avenue, annex.
Smith, William S., 330 North Charles street.
Spear, Irving, 650 Columbia avenue.
Spragins, Melchijah, 1802 St. Paul street.
Spruill, St. Clair, 1002 Cathedral street.
Stiefel, John G., 708 George street.
Stokes, William Royal, 1639 North Calvert street.
Streett, David, 712 Park avenue.
Strobel, Edgar Randolph, 37 East North avenue.
Talbott, Thomas J., 2505 Pennsylvania avenue.
Taneyhill, George Lane, 1103 Madison avenue.
Taneyhill, George Lane, Jr., 1103 Madison avenue.
Tannar, Frederick N., 317 North Carrollton avenue.
Tarun, William, 613 Park avenue.
Taylor, Robert Tunstall, 2000 North Charles street.
Thalwitzer, Marie E., 814 West Fayette street.
Thayer, William Sydney, 406 Cathedral street.
Theobald, Samuel, 304 West Monument street.
Thiede, Gustav A., 705 North Carrollton avenue.
Thomas, Henry Briscoe, 1007 Cathedral street.
Thomas, Henry M., 1228 Madison avenue.
Tiffany, Louis McLane, 831 Park avenue.
Todd, Martillus L., 1202 East Monument street.
Tompkins, John Almy, 905 Cathedral street.
Trimble, Isaac Ridgway, 8 West Madison street.
Tumbleson, Arthur Lee, 2013 Bank street.
Tweedie, Hedley V., 640 North Carrollton avenue.
Uhler, John Reese, 661 West Fayette street.
Ullrich, J. Harry, 11 North Carey street.
Ullman, Alfred, 1526 North Broadway.
Ulman, Solomon Jay, 1725 Park avenue.
Underhill, Albert James, 1822 North Charles street.
Urquhart, Richard A., 849 Park avenue.
Van Ness, Eugene McE., 1631 Park avenue.
Van Williams, Virano, 701 West Fayette street.
Voeglein, Mary Fussell, 1028 Valley street.
Waldkoenig, Christian, 603 South Sharp street.
Warfield, Mactier, 700 North Howard street.
Warfield, Ridgly Brown, 845 Park avenue.
Warner, Robert A., 873 West Lombard street.
Waters, Mary Augusta, 1711 Madison avenue.
Watson, William Topping, 5 West Preston street.
Wegefarth, Arthur, 1207 East Monument street.
Wegefarth, George C., 305 Calvert Building.
Welch, Erberle Geddings, 607 North Charles street.
Welch, William Henry, 807 St. Paul street.

Welsh, Lilian, The Arundel.
Wheeler, Edwin Miles, 2129 West North avenue.
White, Walter Walton, Jr., 1101 North Broadway.
White, William Kelso, 1101 North Broadway.
Whitehead, Alfred, 1215 Madison avenue.
Whitney, Edward L., 1103 Linden avenue.
Whitridge, Andrew Henderson, 840 Park avenue.
Whitridge, William, 829 North Charles street.
Wiegand, William Edward, 1011 Madison avenue.
Wilkins, George Lawson, 6 North Broadway.
Williams, Dudley, 3 West Biddle street.
Williams, John Whitridge, 1128 Cathedral street.
Willis, Mary C., 810 Hanover street.
Wilson, Gordon, 806 Cathedral street.
Wilson, Henry Merryman, 1008 Madison avenue.
Wilson, Lot Ridgely, 1735 Hollins street.
Wilson, Robert Taylor, 820 Park avenue.
Wiltshire, James Gerard, 819 North Eutaw street.
Winner, Jacob Louis, 1735 Bank street.
Winsey, Whitfield, 1220 East Fayette street.
Winslow, John Randolph, 114 West Franklin street.
Winslow, Randolph, 1900 Mt. Royal terrace.
Winternitz, Louis Charles, 116 South Broadway.
Wise, Edward Martin, 706 North Howard street.
Wolf, William B., 13 West Franklin street.
Woods, Hiram, Jr., 842 Park avenue.
Worthington, Thomas Chew, 1022 Madison avenue.
Young, Hugh Hampton, 330 North Charles street.
Zepp, James Albert, 3050 West North avenue.

Allegany County Medical Society.

Barkdall, Frank L., Cumberland, Md.
Boucher, S. A., Barton, Md.
Broadrup, George L., Cumberland, Md.
Carpenter, James H., Midland, Md.
Claybrook, Edwin B., Cumberland, Md.
Cobey, James C., Frostburg, Md.
Doerner, John A., Cumberland, Md.
Duke, Edgar T., Cumberland, Md.
Fechtig, Robert Y., Cumberland, Md.
Foard, William R., Cumberland, Md.
Fochtman, Fred W., Cumberland, Md.
Franklin, A. Leo, Cumberland, Md.
Gardner, Charlotte B., 20 South Liberty street, Cumberland, Md.
Griffith, Timothy, Frostburg, Md.
Harris, Edward, Jr., Cumberland, Md.
Hawkins, Arthur H., Cumberland, Md.
Hodges, William R., Cumberland, Md.
Johnson, John T., Cumberland, Md.
Jones, Emmett L., Cumberland, Md.

Koon, Thomas W., Cumberland, Md.
McDonald, Thomas B., Cumberland, Md.
McGann, John H., Barton, Md.
O'Neil, Francis P., Midland, Md.
Owens, Charles L., Cumberland, Md.
Price, James Marshall, Frostburg, Md.
Skilling, W. Quail, Lonaconing, Md.
Smith, Algernon G., Midland, Md.
Twigg, William F., Cumberland, Md.
Wailes, Henry Stevenson, Cumberland, Md.
Walker, Abbott R., Frostburg, Md.
White, Edward H., Cumberland, Md.
Wilson, J. Jones, Cumberland, Md.

Anne Arundel County Medical Society.

Anderson, Samuel H., Woodwardville, Md.
Billingslea, James Snow, Arminger, Md.
Brayshaw, Joseph Lacy, Friendship, Md.
Brayshaw, Thomas H., Glen Burnie, Md.
Brooke, Charles H., Brooklyn, Md.
Claude, W. Clement, Annapolis, Md.
Davidson, Benjamin Reed, Davidsonville, Md.
Gantt, H. B., Millersville, Md.
Henkel, Charles B., Annapolis, Md.
Henkel, Louis B., Jr., Annapolis, Md.
Hepburn, Sewall S., Annapolis, Md.
Hopkins, Walton H., Annapolis, Md.
Murphy, James J., Annapolis, Md.
Perrie, A. H., McKendree, Md.
Purvis, Jesse Oliver, Annapolis, Md.
Ridout, Z. D., St. Margaret, Md.
Stallings, Albert S., Annapolis, Md.
Thompson, Frank H., Annapolis, Md.
Welch, William S., Annapolis, Md.
Wells, George, Annapolis, Md.
Winterson, Charles R., Elkridge, Md.
Worthington, Joseph Muse, Annapolis, Md.

Baltimore County Medical Society.

Benson, Benjamin R., Cockeysville, Md.
Benson, James Edward, Cockeysville, Md.
Bowen, Josiah S., Mt. Washington, Md.
Brush, Edward N., Towson, Md.
Bussey, Bennett F., Texas, Md.
Bussey, Thomas C., Texas, Md.
Campbell, William H. H., Owings Mills, Md.
Cassidy, Henry F., 408 Roland avenue, Roland Park, Md.
Corse, William D., Gardenville, Md.
Cox, Newman H. D., Arlington, Md.
Drach, John H., Butler, Md.
Dunton, William Rush, Jr., Towson, Md.

Emory, Thomas H., Monkton, Md.
Garrett, Robert Edward, Catonsville, Md.
Gorsuch, J. F. H., Fork, Md.
Green, John S., Gittings, Md.
Green, Joshua Royston, Towson, Md.
Gundry, Alfred T., Catonsville, Md.
Gundry, Lewis H., Relay, Md.
Gundry, Richard F., Catonsville, Md.
Hall, Thomas B., Mt. Winans, Md.
Hardesty, Robert Franklin, Arlington, Md.
Harrison, Henry T., Loch Raven, Md.
Hebb, Henry James, Randallstown, Md.
Hess, H. C., Station H, Govans, Md.
Hill, Charles G., Arlington, Md.
Hocking, George H., Govanstown, Md.
Jarrett, H. S., Towson, Md.
Jarrett, J. H., Towson, Md.
Keating, Frank W., Owings Mills, Md.
Macgill, Charles G. W., Catonsville, Md.
Macgill, John Charles, Catonsville, Md.
Massenberg, Richard C., Towson, Md.
Mattfeldt, Charles L., Catonsville, Md.
Mitchell, A. R., Hereford, Md.
Monmonier, J. Carroll, Jr., Dickeyville, Md.
Naylor, Harry A., Pikesville, Md.
Naylor, Henry L. P., Pikesville, Md.
Patterson, Francis W., Catonsville, Md.
Peltekian, Hovhanness Kevork, Sparrows Point, Md.
Piper, Jackson, Towson, Md.
Porter, Minor Gibson, Roland Park, Md.
Price, T. Rome, Glyndon, Md.
Shipley, Harry F., Granite, Md.
Smart, L. Gibbons, Lutherville, Md.
Smith, William L., Sherwood, Md.
Stevenson, H. Burton, Rider, Md.
Todd, William J., Mt. Washington, Md.
Wade, J. Percy, Catonsville, Md.
West, Marshall B., Catonsville, Md.
Whiteford, William T. G., Parkville, Md.
Whiteley, Benjamin., Catonsville, Md.
Wilson, James H., Fowblesburg, Md.
Winterode, Robert Preston, Catonsville, Md.
Woodward, James S., Sparrows Point, Md.
Wyse, William P. E., Pikesville, Md.

Calvert County Medical Society.

Briscoe, Philip, Mutual, Md.
Chambers, George F., Lusbys, Md.
Chaney, Thomas M., Chaney, Md.
Hinman, Ellsworth H., Lower Marlboro, Md.
King, Isaac N., Barstow, Md.

Leitch, John W., Huntingtown, Md.
Marsh, William H., Solomon's Island, Md.
Paddy, Estep, Barstow, Md.
Talbot, William H., Willows, Md.

Caroline County Medical Society.

Organization not effectual.

Carroll County Medical Society.

Bare, S. Luther, Westminster, Md.
Billingslea, James H., Westminster, Md.
Birnie, Clotworthy, Taneytown, Md.
Bromwell, John E., Ridgeville, Md.
Brooks, Francis T., New Windsor, Md.
Brown, George H., New Windsor, Md.
Carey, Charles J., Sykesville, Md.
Clarke, Joseph Clement, Sykesville, Md.
Coonan, Thomas J., Westminster, Md.
Cronk, Abraham T., Taylorsville, Md.
Cronk, Edwin D., Winfield, Md.
Diller, Charles H., Detour, Md.
Foutz, Charles R., Westminster, Md.
Gaver, William E., Mt. Airy, Md.
Heffenger, Clarence W., Sykesville, Md.
Hering, Joseph T., Westminster, Md.
Hering, Joshua W., Westminster, Md.
Hoff, David E., Union Bridge, Md.
Kemp, Luther, Uniontown, Md.
Morris, John Norfolk, Sykesville, Md.
Norris, Milton D., Eldersburg, Md.
Roop, C. E., Taneytown, Md.
Seiss, F. H., Taneytown, Md.
Sprecher, Daniel B., Sykesville, Md.
Stewart, Jacob J., Union Mills, Md.
Waters, Somerset R., Watersville, Md.
Weaver, John F. B., Manchester, Md.
Wells, William D., Westminster, Md.
Wertz, T. H., Lineboro, Md.
Winterson, George Craggs, New Windsor, Md.
Woodward, Lewis K., Westminster, Md.
Ziegler, John S., Melrose, Md.

Cecil County Medical Society.

Black, Robert M., Cecilton, Md.
Bratton, Howard, Elkton, Md.
Carrico, Camillus P., Cherry Hill, Md.
Cawley, William D., Elkton, Md.
Clemson, Harry E., Port Deposit, Md.
Conrey, Thomas J., Chesapeake City, Md.
Dare, George S., Rising Sun, Md.

Ellis, Charles Manly, Elkton, Md.
Fisher, Samuel Groome, Jr., Port Deposit, Md.
France, Joseph Irwin, Port Deposit, Md.
Gifford, David L., North East, R. F. D., Md.
Housekeeper, Philip B., North East, Md.
Jamar, John Henry, Elkton, Md.
Laws, Clifton C., Chesapeake City, Md.
Miller, Charles F., North East, Md.
Mitchell, Henry Arthur, Elkton, Md.
Rich, Herbert L., Port Deposit, Md.
Roman, Samuel T., Conowingo, Md.
Rowland, Ernest, Liberty Grove, Md.
Stump, George M., Perryville, Md.
Taylor, Leslie George, Perryville, Md.
Worrall, Theodore A., North East, Md.
Wright, Jesse J., Warwick, Md.

Charles County Medical Society.

Bicknell, George C., Pisgah, Md.
Carrico, Louis C., Bryantown, Md.
Chappelear, Henry C., Hughesville, Md.
Digges, John T., Port Tobacco, Md.
Gough, Thomas Reeder, Newburg, Md.
Hannon, Samuel L., La Plata, Md.
Hawkins, P. W., La Plata, Md.
Higdon, Thomas L., Wayside, Md.
Mitchell, John W., Pomonkey, Md.
Monroe, George Ovelton, Waldorf, Md.
Owens, Thomas S., La Plata, Md.
Posey, Cataldus H., Faulkner, Md.
Speake, Samuel H., Grayton, Md.
Spencer, Ernest, Bel Alton, Md.

Dorchester County Medical Society.

Brotemarkle, Clinton, Vienna, Md.
Goldsborough, Brice W., Cambridge, Md.
Goldsborough, M. W., Cambridge, Md.
Houston, William H., Fishing Creek, Md.
Jones, Edgar A. P., Crapo, Md.
Linthicum, Richard L., Church Creek, Md.
Mace, John, Cambridge, Md.
Myers, George Roger, Hurlock, Md.
Osler, E. R., Galestown, Md.
Price, Robert J., Vienna, Md.
Shriver, Joseph K., Jr., Taylor's Island, Md.
Smith, Benjamin L., Madison, Md.
Steele, Guy, Cambridge, Md.
Stokes, Sydney A., Cambridge, Md.
Travers, John C., Cambridge, Md.
Wolff, Eldridge E., Cambridge, Md.

Frederick County Medical Society.

Beatty, Joseph E., Point of Rocks, Md.
Beckley, E. L., Middletown, Md.
Birely, Morris A., Thurmont, Md.
Brawner, John B., Emmittsburg, Md.
Browning, Ralph, Myersville, Md.
Claggett, Samuel, Petersville, Md.
Crum, C. W. R., Jefferson, Md.
Devilbiss, David M., Woodville, Md.
Downey, Jesse W., New Market, Md.
Downey, Jesse W., Jr., New Market, Md.
Fahrney, Henry P., Frederick, Md.
Fout, Raymond Claude, Kemptown, Md.
Getzendanner, J. W., Beaver Creek, Md.
Goldsborough, Charles W., Walkersville, Md.
Goodell, Charles F., Frederick, Md.
Goodman, James Monroe, Frederick, Md.
Haffner, Samuel T., Frederick, Md.
Hedges, Henry Slicer, Brunswick, Md.
Hendricks, John Oliver, Frederick, Md.
Horine, Arlington G., Brunswick, Md.
Johnson, William Crawford, Frederick, Md.
Kable, William H., Woodsboro, Md.
Lamar, Austin A., Middletown, Md.
Lieb, Joseph H., Mt. Pleasant, Md.
Ligget, John J., Ladiesburg, Md.
Long, James A., Frederick, Md.
Long, Wilson A., Frederick, Md.
McCurdy, Ira Jay, Frederick, Md.
McKinney, David F., Limekiln, Md.
Miller, Thomas E. R., Lewistown, Md.
Mullinix, Elisha E., Urbana, Md.
Neighbors, Eutaw D., Lewistown, Md.
Ramsburg, Daniel E., Frederick, Md.
Riggs, George Henry, Ijamsville, Md.
Routson, Thomas Clyde, Buckeystown, Md.
Sappington, C. T., Frederick, Md.
Sidwell, Frank H., Johnsville, Md.
Smith, Alvey J., Wolfsville, Md.
Smith, Franklin Buchanan, Frederick, Md.
Stone, Daniel Edwin, Mt. Pleasant, Md.
Stone, Daniel Edwin, Jr., Emmittsburg, Md.
Stone, Otis B., Libertytown, Md.
Thomas, Bernard O., New Market, Md.
Thomas, Joseph G., Adamstown, Md.
Trapnell, Richard W., Point of Rocks, Md.
Wachter, Charles L., Sabillasville, Md.
Wagner, Wm. H., Woodsboro, Md.
West, Levin, Brunswick, Md.
Yourtee, George William, Burkittsville, Md.
Zimmerman, Michael J., Walkersville, Md.

Garrett County Medical Society.

Cole, James K., Deer Park, Md.
Fazenbaker, C. J., Swanton, Md.
Hinebaugh, Mallon C., Oakland, Md.
Laughlin, J. W., Mountain Lake Park, Md.
Legge, John Edwin, Oakland, Md.
Lininger, G. L., Deer Park, Md.
McComas, H. W., Oakland, Md.
Mason, Allen J., Friendsville, Md.
Selby, J. G., Eglon, W. Va.

Harford County Medical Society.

Archer, William S., Bel Air, Md.
Bagley, Charles, Bagley, Md.
Hollingsworth, Charles A., Bel Air, Md.
Hughes, Frederick Lee, Gibson, Md.
Page, Robert Stevens, Bel Air, Md.
Richardson, Charles, Bel Air, Md.
Roth, Charles E., Edgewood, Md.
Sappington, Purnell Fletcher, Bel Air, Md.
Van Bibber, Armfield Franklin, Bel Air, Md.

Howard County Medical Society.

Byrne, Bernard James, Ellicott City, Md.
Cissel, William W. L., Highland, Md.
Eareckson, William Rose, Elkridge, Md.
Fort, Samuel Jayne, Ellicott City, Md.
Gambrill, William Bartlett, Alberton, Md.
Hebb, John W., West Friendship, Md.
Lacy, John William, Lisbon, Md.
Linthicum, Thomas Waters, Savage, Md.
Miller, Frank O., Alberton, Md.
Nichols, Samuel A., Dayton, Md.
Owings, Levin Gillis, Ellicott City, Md.
Rogers, John M. B., Ellicott City, Md.
Sims, Joseph W., Glenwood, Md.
Stone, William Carter, Ellicott City, Md.
Tumblesome, Charles, Guilford, Md.
Williams, Arthur, Elkridge, Md.

Kent County Medical Society.

Hines, William Franklin, Chestertown, Md.
Maxwell, William Steele, Still Pond, Md.
Simpers, Harry G., Chestertown, Md.
Smith, Frank W., Chestertown, Md.
Whaland, Charles W., Chestertown, Md.
Willson, Thomas B., Edesville, Md.

Montgomery County Medical Society.

Anderson, Edward, Rockville, Md.
Boyer, George M., Damascus, Md.

Brooke, Roger, Sandy Spring, Md.
Brown, William T., Silver Spring, Md.
Chappell, J. W., Grant road N. W., Tenley, D. C.
Deets, James E., Clarksburg, Md.
Dyson, Vernon H., Laytonsville, Md.
Etchison, Elisha C., Gaithersburg, Md.
Farquhar, Charles, Olney, Md.
Green, W. F., Brookeville, Md.
Haddox, Horace B., Gaithersburg, Md.
Jones, Eugene, Kensington, Md.
Jones, G. Wilson, Burtonsville, Md.
Lansdale, Philemon S., Damascus, Md.
Lewis, John Latane, Bethesda, Md.
Lewis, William L., Kensington, Md.
Linthicum, Otis M., Rockville, Md.
Magruder, William Edward, Sandy Spring, Md.
Manner, Claiborne H., Rockville, Md.
Morgan, James Dudley, Chevy Chase, Md.
Moulden, William R., Bethesda, Md.
Muncaster, Stuart B., Rockville, Md.
Nourse, Upton D., Dawsonville, Md.
Pratt, William T., Potomac, Md.
Simpers, Isaac Newton, Germantown, Md.
Stabler, August, Brighton, Md.
Stonestreet, James H., Barnesville, Md.

Prince George County Medical Society.

Birdsall, Charles W., Hyattsville, Md.
Coe, John Alexander, T. B., Md.
Coggins, Jesse C., Laurel, Md.
Cronmiller, John D., Laurel, Md.
Duvall, John M., Springfield, Md.
Etienne, Arthur O., Berwyn, Md.
Eversfield, W. O., College Park, Md.
Fox, Charles A., Beltsville, Md.
Gibbons, William H., Croom, Md.
Griffith, Lewis Allen, Upper Marlboro, Md.
Harley, Richard C., Laurel, Md.
Latimer, Guy W., Hyattsville, Md.
McDonnell, Henry B., College Park, Md.
McMillan, Samuel M., Riverdale, Md.
Nally, Harry, Mt. Rainier, Md.
Perry, Van Leer, Hyattsville, Md.
Postley, Charles E., Hyattsville Md.
Taylor, William F., Laurel, Md.
Willis, H. F., Hyattsville, Md.

Queen Anne's County Medical Society.

Coppage, William G., Church Hill, Md.
Corkran, James M., Centreville, Md.

Dudley, Norman S., Church Hill, Md.
Fenby, Walter H., Ruthsburg, Md.
Ford, R. H., Queenstown, Md.
Graham, James E., Ingleside, Md.
Hackett, Robley, Queen Anne, Md.
Henry, William T., Stevensville, Md.
Hopkins, Howard R., Queenstown, Md.
Reading, Laura E., Hayden, Md.
Smith, Ernest F., Centreville, Md.
Stack, James W., Wye Mills, Md.
Sudler, Foster, Sudlersville, Md.
Weedon, John H. W. G., Church Hill, Md.

St. Mary's County Medical Society.

Greenwell, Francis Floyd, Leonardstown, Md.
Hodgdon, Alexander L., Pearson P. O., Md.
King, Joseph O., Oakville, Md.
Lloyd, P. H., Ridge, Md.
Lynch, Thomas H., Leonardstown, Md.
Palmer, Robert Vickory, Palmers, Md.

Somerset County Medical Society.

Alexander, Harvey G., Deal's Island, Md.
Atkinson, Gordon T., Crisfield, Md.
Collins, Clarence E., Crisfield, Md.
Coulbourne, William H., Crisfield, Md.
Dickinson, Granville E., Upper Fairmount, Md.
Fisher, Charles T., Princess Anne, Md.
Fisher, W. H., Princess Ann, Md.
Hall, William Fletcher, Crisfield, Md.
Hoyt, Ralph L., Oriole, Md.
Lankford, Henry M., Princess Anne, Md.
Schwatka, C. T., Deal's Island, Md.
Simonson, Gordon T., Crisfield, Md.
Smith, Teackle J., Princess Anne, Md.
Somers, J. Fletcher, Crisfield, Md.
Wainwright, Charles W., Princess Anne, Md.
Ward, Christopher C., Crisfield, Md.
Windsor, Samuel J., Dames Quarter, Md.

Talbot County Medical Society.

Chaplain, James S., Trappe, Md.
Davidson, Charles F., Easton, Md.
Dodson, R. B., St. Michaels, Md.
Hayward, Alexander Bailey, Easton, Md.
McCormick, J. L., Trappe, Md.
Marshall, William, Jr., Easton, Md.
Merritt, James B., Easton, Md.
Seth, Joseph B., McDaniel, Md.
Seymour, William S., Trappe, Md.

Stevens, James A., Easton, Md.
Travers, Philip Lee, Easton, Md.
Trippe, Edward R., Easton, Md.
Wilson, S. Denny, Easton, Md.
Wilson, S. Kennedy, Tilmans, Md.

Washington County Medical Society

Baker, Charles D., Rohrersville, Md.
Boose, Theodore B., Hagerstown, Md.
Davies, S. Seibert, Boonsboro, Md.
Derr, Hamilton K., Hagerstown, Md.
Eirly, Clara S., Hagerstown, Md.
Foster, Henry C., Clearspring, Md.
Gardner, S. Howell, Sharpsburg, Md.
Herman, Henry S., Hagerstown, Md.
Humrichouse, James W., Hagerstown, Md.
Kefauver, Maurice D., Smithsburg, Md.
Keller, Luther H., Hagerstown, Md.
Laughlin, Mary A., Hagerstown, Md.
McCauley, Charles S., Hagerstown, Md.
Maisch, Augustus C., Hagerstown, Md.
Mason, Augustine S., Hagerstown, Md.
Miller, D. C. R., Mason & Dixon, Pa.
Miller, Victor Davis, Jr., Hagerstown, Md.
Miller, William Preston, Hagerstown, Md.
Morrison, William B., Hagerstown, Md.
Nihiser, Winton M., Keedysville, Md.
Perry, Jonathan P., Clearspring, Md.
Pittsnogle, Jeptha E., Hagerstown, Md.
Protzman, Joseph, Smithsburg, Md.
Quinn, William Alexander, Chewsville, Md.
Ragan, O. H. William, Hagerstown, Md.
Reichard, V. Milton, Fairplay, Md.
Richardson, William S., Williamsport, Md.
Scheller, Christian R., Hagerstown, Md.
Schindel, E. M., Hagerstown, Md.
Scott, John McPherson, Hagerstown, Md.
Shank, Abraham R., Clearspring, Md.
Tabler, Homer E., Hancock, Md.
Wade, John H., Boonsboro, Md.
Wagaman, Samuel M., Hagerstown, Md.
Wareham, Edward A., Hagerstown, Md.
Watkins, Daniel A., Hagerstown, Md.
Wertz, Irwin M., Williamsport, Md.
West, James A., Hancock, Md.

Wicomico County Medical Society.

Dick, James McFaddin, Salisbury, Md.
Elderdice, John Martin, Mardella Springs, Md.
Humphreys, Eugene W., Salisbury, Md.

Morris, Louis W., Salisbury, Md.
Slemons, Francis M., Salisbury, Md.
Todd, George W., Salisbury, Md.
Wilson, Lewis N., Mardela Springs, Md.

Worcester County Medical Society.

Aydelotte, John S., Snow Hill, Md.
Bennum, Charles H., Girdletree, Md.
Costen, Isaac Thomas, Pocomoke City, Md.
Dickerson, John D., Stockton, Md.
Dirickson, Cyrus W., Berlin, Md.
Dirickson, Edwin J., Berlin, Md.
Hall, R. Lee, Pocomoke City, Md.
Jones, Paul, Snow Hill, Md.
Purnell, J. B. R., Snow Hill, Md.
Quinn, Samuel S., Pocomoke City, Md.
Riley, John L., Snow Hill, Md.
Tyndell, Ira C., Whaleysville, Md.
White, William H., Whiton, Md.

Non-Residents.

Barrow, Bernard, Barrow's Store, Va.
Elgin, W. F., Glenolden, Pa.
Gwyn, Matthew K., South Atlantic Quarantine Station, via Inverness, Ga.
Hartman, George J., Muskegon, Mich.
Hunt, Reid, The Hygienic Laboratory, 25th and E streets N. W., Washington, D. C.
Kahn, Max, 161 Broadway, Long Branch, N. J.
McKim, Smith Hollins, Irvington-on-Hudson, New York.
Marshall, Harry Taylor, Manila, P. I.
Miller, Harold B., 140 South 13th street, Lincoln, Neb.
Morse, Elizabeth, New England Hospital, Rocksbury District, Boston, Mass.
Opie, Eugene L., Rockefeller Institute, New York city, N. Y.
Osler, William, Oxford, England.
Peebles, T. C., Falmouth, Mass.
Purdum, H. D., Traverse City, Mich.
Ramsay, Otto G., New Haven, Conn.
Rusk, Glanville Y., Pathological Institute, Ward's Island, N. Y.
Schild, Edward Henry, Canton, Ohio.
Scott, Jessie M. Thornton, Charleston, W. Va.
Smith, Alan W., Oregonian Building, Portland, Ore.
Sudler, Mervin Tubman, Lawrence, Kan.
Vogel, Charles W., United States Public Health and Marine Hospital Service, Manila, P. I.
Wattenscheidt, Charles, Orlando, Fla.
Wentz, Alexander C., 306 Abbottstown street, Hanover, Pa.

MARYLAND MEDICAL JOURNAL.

JOHN S. FULTON, M.D., *Editor.*

Associate Editors:

THOMAS R. BROWN, M.D. | HUGH H. YOUNG, M.D.
ROBERT REULING, M.D. | JOSE L. HIRSH, M.D.

BALTIMORE, MARCH, 1907

THE PROMOTION OF JAMES CARROLL.

LIEUTENANT JAMES CARROLL of the Army Medical Corps will soon be promoted to be a Major, if the bill reported by the Senate Committee on Military Affairs becomes a law. The promotion is offered in recognition of distinguished services to science and to his country as a member of the Yellow Fever Commission, and the first volunteer in the experimental production of yellow fever by the bite of an infected Stegomyia. It is not pretended that the promotion is an adequate reward. It is simply the measured remuneration which the country can offer for services which are invaluable—an outward and visible sign, denoting, not the limits of the country's gratitude, but a government's mode of expression. That Dr. Carroll will be more than satisfied goes without saying. His sense of equivalence is not very delicate, and he probably believes that the debt of the country to a citizen can never be greater than the debt of a citizen to his country. At all events, Carroll is tall enough to know whether any of Columbia's sons are as tall as their mother.

Republics, it is said, are subject to certain disabilities. By being, for a moment, insensitive to the tone and rhythm of national life, and at the same time oversensitive to the distribution of medals and epaulettes, one may entertain the transient notion that republics are ungrateful. But most of us are not great enough, nor small enough, to discuss the disabilities of republics. The disabilities of heroes are within our range, and far more interesting. Let us go down to Olympia and visit the athletes. Here is one who has recently won his event. He is to be made a major. He cannot be very fast, for any man who keeps the course can be a major at fifty. He is well past fifty, and only a lieutenant. At fifty no one looks good enough for any of the five exercises. Carroll won his fifth in 1902, when, as a member of the Yellow Fever Commission and its technical right hand, he gave his body to the proof that yellow fever is carried by the Stegomyia mosquito. He made the proof, and escaped, as a soldier should, with his life—somewhat impaired, but still able to jog on to his majority. He is to skip the captain's grade. Four or five years earlier Major Walter Reed wanted Carroll as his associate, but Carroll was too old. Reed persuaded the objectors that the disability of age ought not to prevail over Carroll's remarkable technical efficiency. The lesser consideration gave way to the greater, and Carroll was promoted from hospital steward to assistant surgeon. Though serving as a hospital steward, he had been a physician since 1891, when he graduated at the University of Maryland. A good many years earlier another army surgeon, not Dr. Reed, had discovered unusual aptitude in his hospital steward, James Carroll, and had asked that he be given leave to study medicine. Leave was refused at first, but persistent effort secured the permission, and the medical course was finished after much delay and interruption. Before he became a hospital steward, Carroll was a sergeant; before that, a corporal, and before that, a private in the army of the United States since 1874. To one who wishes to become a physician these things are serious stumbling-blocks, especially if one has been a good trooper, a good corporal, a good

sergeant and a good hospital steward, and more especially if one desires to belong to the medical corps of the army.

Before 1874 Carroll was a lad in his teens, chasing a vague future in the wilds of Canada. His roof tree is at Woolwich, England, where he was born of English parents in 1854. This, that he was born in England, is the initial disability of our athlete. Truly the Fates are severe handicappers. Ἅλμα, δίσκος, δρώμος, πάλη, πυγμή, all the honors of the pentathlon belong to Carroll, and Columbia surely must confer some mark of special favor on so devoted a foster son.

A CIVILIZING EPIDEMIC OF SCARLET FEVER.

The world is young, and the ancient instruments of civilization are not yet outworn. The gospel of peace has not delivered us from war and pestilence, but we must continue in their rough tutelage so long as we are less moved by a humane idea than by a brutal spectacle. For men who will not follow the humane impulse nor react to a painful sight there is the discipline of pain. Now as of old, and for men as for cattle, the shortest route from thought to action follows the sting of the lash.

Chicago is passing through a civilizing epidemic of scarlet fever. Many years have gone since scarlet fever visited Chicago in anything like epidemic proportions. It is one of the characteristics of the disease that epidemic waves of extraordinary height occur at long intervals. The Health Department of Chicago estimates that in the interval since the last epidemic the city accumulated a population of 441,000 children under the age of ten years, of whom 400,000 were susceptible to scarlet fever. This estimate is based on a total population somewhat above 2,000,000. The registrar of that city is not good at figures. If he were better acquainted with his population he would have estimated the number of children under ten at 456,000, and with a better knowledge of scarlet fever the number of susceptibles in that age would have been estimated below 400,000. There is no doubt, however, that the population had acquired a high degree of susceptibility. The Chicago Health Department was prepared for the emergency, just as that of Baltimore is, with inadequate inspection of schools and no isolation hospital. The disease made its invasion by the usual and reliable device. At first the number of recognized and reported cases did not increase rapidly. When the profession and the public awoke to current events it was discovered that the city had been widely seeded by means of mild and unrecognized cases, many of them running their course without medical attention. At the height of the epidemic nearly 2000 cases were recorded in a single week.

The usual psychologic phenomena occurred. The Health Department was severely criticised, and the Department reacted to this injustice in the usual way. The Department was said to be doing less, and the Department professed to be doing more, than could be done with its equipment. The fire of criticism was turned upon the City Council, and the needs of the situation soon became acutely manifest. The Health Department was enabled to increase its number of school inspectors to 350. For the time being this means the medical inspection of every school in the city every day. Fancy the gayety of the City Council of Baltimore in responding to a request of the Health Commissioner for 115 medical inspectors!

Chicago has also realized painfully the need of an isolation hospital; and the difficulties which in Chicago, as in Baltimore, have surrounded this project are now to be swept away as utterly insignificant in the presence of a public necessity so urgent. Citizens of Chicago are now persuaded

that an isolation hospital is a beneficent institution and greatly to be de-
that an isolation hospital is a beneficent institution, and greatly to be de-
within easy reach of the sick, and visible from a passing trolley line.

The wisdom which has come to Chicago in the wake of an epidemic may come to Baltimore in the same way. The civilizing epidemic is not indispensable, but perhaps it is preferable to the less impressive collection of smaller but avoidable toll which goes on year after year and, in the aggregate, exceeds the cost of an epidemic. A tremendous object-lesson, fully accomplishing needed reforms, might be a life-saving experience.

THE PECUNIARY REWARDS OF MEDICINE.

The *Medical Record,* in summarizing the causes of alleged diminution of professional income, says that two potent causes are usually overlooked. "These are the decrease in morbidity, and the greatly improved methods of treatment of the present day." "Hygiene and sanitation," the editorial continues, "have abolished many of the great epidemics of disease which in times past were wont to bring much grist to the doctor's mill, while the introduction of new and more scientific modes of treatment have to a great extent curtailed the duration of disease and have in a corresponding degree reduced the doctor's income."

Unfortunately, the editor of the *Record* is wrong on both points of his argument. The influence of preventive medicine and of improved curative medicine are often enumerated among the causes of diminishd professional income, and both of these influences increase, instead of diminishing, the earning power of the profession. Preventive medicine, when it reaches its highest development, will not deliver the world from *amounts* of morbidity, but from *kinds* of morbidity. Since man must die, the prevented causes of death must be replaced by non-preventable causes of death. The field of activity in medical practice will in future be very materially changed, but the demand for medical services can not possibly diminish. On the contrary, it will increase, and the pecuniary rewards of such services will increase.

It costs as much to prevent disease as to cure it; and public funds are spent on preventive medicine, not because prevention is cheaper than cure, but because prevention is worth more than cure. The amount of public money now spent in prevention is very large, and much of it goes into the private purses of physicians. The number of physicians who are wholly supported by work in public hygiene is very large, and the limits of professional activity in this line are nowhere near in sight.

Modern therapeutic resources do not cheapen medical services. The pecuniary value of the curative art has steadily enhanced as the results of treatment have improved. Surgeons, obstetricians, and pediatrists do not find the average time of attendance in individual cases very much shortened. They have occupied large fields of life-saving which were fast closed, some of them hopelessly closed, to their grandfathers. In every department of medicine, even in general practice, our beneficent science has vastly more to offer than the medicine of fifty years ago could offer, and the people are as eager and more able to buy. It may be true now, as formerly, that the medical profession is underpaid, but the average professional income in the United States is probably larger today than it was fifty years ago. For the well-trained young man the outlook now is much brighter than ever before. For the ill-trained, who had good chances fifty years ago, the prospect today is, indeed, that of despair.

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, December 12. 13, 14 and 15, 1906.

No.	College of Graduation.	Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Materia Medica	Therapeutics	Physiology	Total	Average
1	Baltimore Medical, '04	78	70	72	75	72	76	82	79	71	675	75
2	Maryland Medical, '06	38	85	40	75	69	12	70	74	75	538	59
3	Baltimore Medical, '06	75	60	53	75	85	70	80	65	60	623	69
4	College of Physicians and Surgeons, '03	91	90	79	85	91	68	95	90	70	759	84
5	*Maryland Medical, '04	..	80	75	..	..	78	..	..	..	...	..
6	†	..	..	..	..	..	..	..	..	..	...	..
7	Leonard Medical, '05	91	80	77	85	87	82	88	83	77	750	83
8	George Washington University, '05	76	90	85	90	79	62	87	83	80	732	81
9	*Baltimore Medical, '06	29	..	47	..	69	73	..	..	..	...	..
10	*University of Maryland, '06	75	..	77	..	..	75	82	82	..	...	..
11	College of Physicians and Surgeons, '06	85	95	90	85	87	89	93	93	80	797	88
12	George Washington University, '06	85	75	59	80	77	35	70	73	80	634	70
13	*Jefferson Medical, '06	65	..	57	..	..	75	..	..	..	...	..
14	*Baltimore Medical, '06	..	80	88	..	..	96	88	..	..	...	..
15	George Washington University, '06	86	85	75	75	78	63	59	88	67	676	75
16	*University of Pennsylvania, '94	75	..	75	..	..	75	..	95	75	...	..
17	University of Maryland, '06	89	75	80	60	75	94	61	69	72	675	75
18	*University of Maryland, '05	84	..	..	..	..	75	..	..	..	...	..
19	‡University of Maryland, '05	0	Dismissed from examination for cheating.									
20	Leonard Medical, '05	75	80	63	75	73	52	71	57	70	616	68
21	Johns Hopkins, '03	81	85	93	85	82	81	93	92	85	777	86
22	*University of Maryland, '05	..	..	75	..	75	75	85	82	..	...	..
23	‡University of Maryland, '05	82	..	..	..	..	89	95	..	80	...	..
24	*University of Maryland, '02	..	..	75	..	..	..	..	..	..	...	..
25	*Maryland Medical '05	75	..	..	..	..	..	88	85	75	...	..
26	Howard University, '06	81	90	75	90	75	75	82	67	85	720	80
27	*University of South, '04	46	..	40	..	..	..	..	..	..	...	..
28	Baltimore Medical, '06	90	90	95	90	88	92	90	78	96	809	89
29	*Georgetown University, '04	..	..	75	..	..	75	..	..	..	...	..
30	*College of Physicians and Surgeons, '06	60	..	77	..	78	60	..	..	..	...	..
31	*College of Physicians and Surgeons, '04	..	..	36	..	66	35	55	82	75	...	..
32	*Maryland Medical, '04	32	80	35	..	64	51	..	..	..	...	..
33	*Baltimore Medical, '06	75	..	77	..	83	75	..	..	80	...	..
34	*Maryland Medical, '06	23	..	..	..	..	44	63	67	72	...	..
35	George Washington University, '06	69	95	77	100	81	75	90	85	80	752	83
36	Johns Hopkins, '06	84	95	85	80	86	79	94	95	93	791	87
37	*Baltimore Medical, '06	29	..	..	..	..	..	..	..	..	...	..
38	*University of Maryland, '04	..	..	75	..	..	75	75	87	..	...	..
39	University of Pennsylvania, '06	69	98	76	80	84	75	75	80	75	712	79
40	Maryland Medical, '06	21	75	63	90	72	30	77	91	63	582	64
41	University of Maryland, '06	53	95	61	75	77	35	87	92	77	652	73
42	Howard Medical, '06	82	90	62	80	79	61	80	68	75	677	75
43	†	..	..	..	..	..	..	..	..	..	...	..
44	*Maryland Medical, '06	66	75	67	..	..	40	..	..	75	...	..
45	Maryland Medical, '05	60	75	95	65	76	76	80	95	90	712	79
46	*Baltimore Medical, '03	..	..	62	..	76	50	78	73	..	...	..
47	*Baltimore University, '03	35	..	29	..	58	31	..	82	66	...	..
48	University of Maryland, '06	76	85	75	100	76	63	92	94	65	726	80
49	George Washington University, '06	90	70	77	85	90	75	81	83	71	722	80
50	*University of Maryland, '05	43	..	75	..	81	58	..	..	..	...	..
51	*Maryland Medical, '06	38	..	53	..	..	..	..	..	..	...	..
52	College of Physicians and Surgeons, '06	75	95	94	90	88	93	96	93	80	794	88
53	*Maryland Medical, '05	..	..	25	..	..	..	..	..	..	...	..
54	*University of Maryland, '06	..	..	67	..	..	59	72	..	..	...	..
55	‡College of Physicians and Surgeons	93	..	..	..	..	79	87	..	90	...	..
56	*Baltimore University, '02	65	..	67	..	..	41	..	..	..	...	..
57	*Maryland Medical, '05	88	..	45	..	..	47	..	..	..	...	..
58	Johns Hopkins, '05	89	90	92	80	87	86	80	88	80	772	85
59	*University of Maryland, '06	..	..	55	..	..	65	82	..	70	...	..
60	*University of Maryland, '04	75	..	76	..	..	..	..	..	..	...	..
61	§Ohio Medical, '03	51	..	..	..	..	..	..	..	..	...	..
62	*Baltimore University, '03	46	Dismissed from examination for cheating.									
63	*Maryland Medical, '06	78	85	78	..	81	75	..	..	..	...	..
64	§University of Maryland, '04	..	..	..	..	..	..	..	..	..	...	..
65	*University of Maryland, '06	75	..	94	..	..	78	75	..	..	...	..
66	University of Maryland, '05	67	95	82	80	81	75	84	88	95	747	83
67	†	..	..	..	..	..	..	..	..	..	...	..
68	*College of Physicians and Surgeons, '02	..	..	..	..	..	75	..	..	..	...	..

*Re-examinations. ‡Second year students. §Withdrew. †Failed to appear.

Of the 65 applicants in the above list who were present there are 26 who participated in the examination for the first time, of whom 20 were successful. There were 34 applying for re-examination in branches in which they had previously failed; 15 were successful, working off all branches. Primary examinations require a general average of 75. Those re-examined are required to make 75 in each branch. In the above list there were three who took the examination for second-year students who have completed studies in anatomy, chemistry, materia medica and physiology. As will be noted above, two were detected in using information which they had carried into the examination with them, in violation of the rules, and were summarily dismissed.

REPORT OF BOARD OF MEDICAL EXAMINERS OF MARYLAND.

QUESTIONS AT THE DECEMBER (1906) EXAMINATIONS.

ANATOMY.

1. Give origin, insertion and nerve supply of the following muscles: Biceps (flexor cubiti), pterygoids, sartorius, gastrocnemius.

2. Name and give location of the ductless glands.

3. Name cavities of the heart and describe the valves.

4. Superficial and deep origin, course and distribution of the facial nerve.

5. What structures pass (a) through the jugular foramen; (b) through the foramen magnum?

6. Describe the hip joint.

SURGERY.

1. Describe the treatment of fracture of the patella.

2. Describe the fractures commonly designated (a) Pott's fracture; (b) Colles' fracture. Give treatment of each.

3. Tetanus—give its cause, diagnosis, treatment, and modes of prevention.

4. Otitis media—define, classify, and give cause, symptoms, and treatment.

5. Acute glaucoma—define, describe, and give cause and treatment.

6. Describe amputation at middle third of forearm, naming important structures severed.

PATHOLOGY.

1. Name and describe the organisms most frequently associated with the following diseases: Typhoid fever, malarial fever (aestivo-autumnal type), tuberculosis. Give method of staining of each.

2. Describe in their order and explain the cardinal signs of inflammation, and state the terminations of inflammation.

3. State the difference in the gross pathology of acute lobar and broncho-pneumonia, and name the organism most frequently associated with each.

4. Give the avenues of entrance and elimination of the specific organism of typhoid fever. Name what you consider the most characteristic anatomical lesion, and describe in detail the microscopic method of obtaining the Widal reaction.

5. Give the gross pathological anatomy of cerebral apoplexy.

6. Explain what is meant by the terms physiological and pathological leucocytosis, respectively. State whether a leucocytosis is present in the following diseases: Typhoid fever, malarial fever, appendicitis, acute miliary tuberculosis.

GYNECOLOGY AND OBSTETRICS.

1. Describe the care of the new-born child and how you would nourish it the first two or three days, there being an absence of the mother's milk.

2. Name several conditions of the mother that unfit her to nourish the infant.

3. Give the various dimensions of the pelvis and describe what presentations are best adapted to them.

4. What indications require the use of the forceps; give your method of using them, and the danger of their use to mother and child.

5. Describe the mechanism of a breech presentation, and how would you dispose of the cord during the expulsion of the child?

6. Describe the method of delivering a face or frontal presentation.

PRACTICE.

1. Define (a) pertussis, (b) pleurodynia, (c) herpes zoster, (d) pyonephrosis, (e) cholylithiasis.

2. Name symptoms of (a) variola, (b) acute colitis, (c) locomotor ataxia.

3. Differentiate diagnosis between serofibrinous pleurisy, lobar pneumonia, and tubercular consolidation of the lung.

4. By what symptoms could you arrive at the earliest positive diagnosis of typhoid fever?

5. Treatment of (a) chorea, (b) ulcerative stomatitis.

6. Give diagnosis and treatment of early stage of pulmonary tuberculosis.

CHEMISTRY.

1. Define the terms "normal salts," "acid salts," "basic salts." Give the chemical composition of physiological "normal salt solution," with the approximate amounts of each ingredient.

2. Give the formula for the general properties of and the usual source in nature of carbon monoxide and carbon dioxide, respectively.

If inhaled, describe how they act chemically as poisons.

3. Give the chemical composition (formula) and general properties of plaster of paris. Explain in detail the process of setting of plaster.

4. Give the general properties of and name the antidote for carbolic acid (C_6H_6O). Construct its graphic formula and show what relation it bears to benzene (C_6H_6).

5. Name the chief chemical constituents of gallstones and give in detail a test for the detection of bile in the urine.

6. Give in detail a test for the detection of lactic acid in a specimen of gastric contents.

MATERIA MEDICA.

1. Give the chemical name of Epsom salts, Rochelle salts, Glauber salts.

2. Mention the ingredients and give the dose of pulvis glycyrrhizae compositus.

3. Give the composition, dose, and pharmaceutical name of Basham's Mixture.

4. Name three drugs belonging to each of the following classes: (a) Narcotics, (b) diaphoretics, (c) ecbolics.

5. What is the antidote for arsenic and how is it prepared?

6. Give the derivation of opium. What amount of (a) powdered opium, (b) tincture opium, (c) camphorated tincture of opium would equal in effect one-fourth grain morphia sulphate?

THERAPEUTICS.

1. Define therapeutic incompatibility, chemical incompatibility, and give illustration of each.

2. Describe hypodermoclysis and the conditions in which it is practiced as a therapeutic means.

3. Write a compound prescription for an adult suffering from insomnia.

4. Write a prescription containing at least two drugs for an adult suffering from acute articular rheumatism.

5. Mention three drugs to accelerate the action of the heart and give the dose of some official preparation of each.

6. Name three drugs used to retard the action of the heart and give the dose of some official preparation of each.

PHYSIOLOGY.

1. (a) Define secretion and excretion. (b) What organs of the body are purely excretory?

2. What disturbances of digestion result from an absence of bile?

3. Enumerate the functions of the cerebellum.

4. (a) Name the fluids of the alimentary canal. (b) Where is the succus entericus formed?

5. How many kinds of muscular tissue are found in the body? Describe each.

6. Describe the main forms of intestinal movement and give some of the conditions that would affect such movement.

Medical Items.

BALTIMORE.

A BRONZE memorial tablet has been placed in the College of Physicians and Surgeons to the memory of the late Dr. Thomas S. Latimer, professor of medicine.

JOHNS HOPKINS UNIVERSITY has received from the estate of Charles L. Marburg the sum of $150,000, of which amount $100,000 goes to the hospital and $50,000 to the university.

DR. ADOLPH EISENBERG of Baltimore was painfully injured on February 19 by being thrown from his carriage. The front axle broke, and the doctor was thrown to the street, damaging his shoulder.

DR. FLORENCE MURDOCH, a daughter of the late Dr. Russell Murdoch and a graduate of the Woman's Medical College of Baltimore, has been visiting relatives in Baltimore, and on March 8 will sail for Shanghai, China, where she will be married to Dr. Andrew Young of Hei-an-fu, China. Dr. Murdoch has been engaged for several years as an associate in Dr. Campbell Morgan's work in London. Dr. Young is a graduate of the University of Glasgow, and has been engaged in missionary work in China.

DR. D. W. SMITH was tried on February 1 on the charge of having failed to report cases of typhoid fever last March during the epidemic of typhoid fever at Woodberry. There were three cases in the family, and they came down at considerable intervals. All three were

reported at one time. The State asked for a conviction on the first case of the series. Dr. Smith's defense was that he did not know that it was a case of typhoid fever until the day he reported it. He was acquitted.

MARYLAND.

"Dr." Oscar Bayson was fined $50 and costs on February 4 for practicing medicine without a license. He lives in Talbot county and is a "herb doctor."

Dr. J. F. Wagner of Hagerstown was arrested on January 30, charged with practicing medicine without a license. In default of $300 bail he was sent to jail.

Dr. Abram J. Williams of Prince Fredericktown, Calvert county, died on January 24 at the age of 58 years. Dr. Williams graduated at the University of Maryland in 1886.

Dr. James H. Miles died at his home near St. Maary's City, St. Mary's county, on January 26, aged 85 years. He was a graduate of the University of Maryland in 1845.

Dr. John E. Bolte, Register of Wills for Baltimore county, died at his home on February 17. Dr. Bolte had been in delicate health for more than a year. He was a graduate of Baltimore Medical College in 1891.

The outbreak of smallpox in Kent county is about over. Dr. S. Wickes Merritt, the physician in charge, has returned to Chestertown to resume practice. Dr. H. G. Simpers, the county health officer, was attacked by influenza while the epidemic was in progress and was confined to his bed for a week. He will go South to recuperate.

A good young physician is wanted at Accokeek, Prince George county, about 15 miles south of Washington, on the Potomac river. It is said that the practice will yield about $2000 a year, judging by the experience of a physician who recently died at Accokeek. Inquiry can be made of Mr. George B. Morton, Accokeek.

Dr. George W. Archer died at his home in Emmorton, Harford county, on February 16. Dr. Archer was one of the oldest physicians in the State and a member of a family which has for more than a century been well known in the annals of the profession in Maryland. His father was Dr. Robert Archer of Harford county. During the Civil War Dr. Archer was a surgeon to Stonewall Jackson's brigade of the Confederate Army. He was 83 years old, and never married.

GENERAL.

The Hospital College of Medicine and the Louisville Medical College have also merged. The new school will be known as the Medical Department of Central University.

The medical departments of Kentucky University and the University of Louisville have been merged. The University of Louisville has bought the buildings of Kentucky University, with its good will and equipment, the consideration being $40,000. The two faculties will be combined.

Dr. George C. Pardee has returned from political to professional life, his term as Governor of California having ended. The Alameda County Medical Society entertained Dr. Pardee at a banquet on January 28 in honor of his faithfulness to professional ideals while in public office.

The Department of Education of the State of New York has approved a bill, now pending at Albany, for the establishment of a single examining board and the abolition of all distinctions of sect in the licensure of medical graduates. The sectarians are bitterly opposed to the bill.

Chicago is having an epidemic of scarlet fever, and new cases were discovered at the rate of 1500 or more a week. Three hundred and fifty medical inspectors of schools have been appointed, and every school has a medical attendant each morning. The municipal hospital project has been somewhat popularized by the epidemic.

The people of Whaleyville, on the Eastern Shore of Virginia, want a physician to replace Dr. R. E. Riddick, who died on February 15. Whaleyville is a village of about 400 people, surrounded by a good agricultural countryside and without a physician. The sawmills of the Jackson Lumber Co. are situated at Whaleyville. Inquiries will be answered by Mr. G. B. Robertson, superintendent of the mills.

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NOTES ON HISTOPLASMOSIS—A FATAL DISORDER MET WITH IN TROPICAL AMERICA.

By Samuel T. Darling, M.D.

Chief, Board of Health Laboratory, Ancon Hospital, Panama.

READ AT THE COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE, MD., JANUARY 11, 1907

Beginning with Major Leishman's and Captain Donovan's researches on *kala-azar,* we have become aware of a small but very important group of disorders which are worthy of some attention. Major Leishman of the R. A. M. C. in May, 1903, called attention to a parasite which he obtained at autopsy from the spleen of a soldier invalided from Dum-Dum, near Calcutta, India. The clinical picture had been that of cachexia, chronic dysentery, splenomegaly and low fever. Major Leishman believed the bodies to be residues of trypanosomes. Shortly afterwards, in July, 1903, Captain Donovan, I. M. S., stated that he had found a similar parasite at autopsy in several cases said to have died of chronic malaria in Madras. The parasite had the same morphology Major Leishman's had, and the clinical features of the disease corresponded closely with Major Leishman's cases.

About this time, December, 1903, Dr. J. H. Wright of Boston described an intracellular parasite obtained from smears and sections in a case of Oriental sore from the person of a young native of the Levant. This parasite closely resembled the Leishman-Donovan body. Marchand and Ledingham came upon a similar organism in the tissues of a soldier dying in Berlin invalided from China. Several observers in Assam, India, China and Egypt reported finding the Leishman-Donovan body in cases of splenomegaly, with emaciation, and also in the granulomata and ulcers known as Oriental sore, Delhi sore or aleppo button. Richard P. Strong of Manila, in 1906, reported a case of ulcerating granuloma in which he found an organism probably belonging to this

class. Lieutenant Christopher and Major James of I. M. S. were ordered to India on special duty to investigate *kala-azar,* malarial cachexia, Delhi sore, and their relation to the Leishman-Donovan body.

Lieutenant Christopher in his report describes the organism of kala-azar and gives the clinical features of the disease, which, in brief, are those of splenomegaly, irregular pyrexia, cachexia and emaciation. He also reports several autopsies, and gives an account of some cultural experiments made with citrated blood. Major James reports in the "Scientific Memoirs of Medical Officers in India": *"Kala-azar* is a disease distinct from any other. Its symptomatology requires to be rewritten. It has no connection with malaria, and its presence and spread depend upon conditions different from those requisite for the presence and spread of that disease. It exists in some places where malaria is not present, and is absent in some places where malaria is intensely prevalent. Its geographical distribution in India is more limited than that of malaria. Subject to correction, as a result of further study, I would say at present that it is confined to low-lying, more or less waterlogged districts, where the rainfall is heavy. In all probability the Leishman-Donovan parasite is present at some period in every case, and very probably is the cause of the disease, but the proof is by no means complete. The geographical distribution of Oriental sore and of *kala-azar* and, therefore, of the parasites found in those two diseases do not correspond, and it is probable that the parasite of these diseases, though indistinguishable in appearance, are different species of a hitherto unknown group of organisms. Probably other species will be discovered in the near future; we may conjecture that they will be found in other diseases than Oriental sore and *kala-azar."* So much for the Old World.

On December 5, 1905, at Ancon Hospital, C. Z., Panama, I found in the tissues of a negro Martiniquan great numbers of parasites resembling somewhat the Leishman-Donovan body, though presenting certain marked differences. On January 31, 1906, I duplicated that experience in another native Martiniquan. Again, on August 6, 1906, from a Chinese who had lived on the Isthmus 15 years, I had the pleasure of renewing my acquaintance with this peculiar little protozoon which had caused the death of the Martiniquans.

The clinical history of these three cases, unfortunately, is incomplete, for the reason that two of the cases died within a few hours after admission to the hospital in a condition of coma or delirium. The disease runs a course of a few months. The Chinese had been going down hill about six months. There is an irregular fever, with emaciation, and splenomegaly, as in *kala-azar.* In case No. 2 the patient complained of diarrhea, tender calves and

burning sensations in his feet. Patient No. 1 was delirious. Patient No. 3 was comatose 12 hours before death. Patient No. 1 presented a marked leukopenia, leucocytosis 2200; hemoglobin was 70 per cent. Malarial parasites were absent. In No. 2 the temperature was not controlled by quinine.

AUTOPSY FINDINGS IN BRIEF.

Emaciation was extreme in cases 1 and 2. Papular eruption on the shoulders in case No. 3. Swelling of ankles in case No. 3. Splenomegaly in cases 1, 2 and 3. The spleen is large, firm, yet friable. It is never flexuous, and it retains its form upon removal from the body. Its weight is from 400 to 700 grammes. Enlargement of liver with small hyaline areas of infiltration by parasites and focal necroses. There was enlargement of the lymph-nodes draining the spleen, liver and intestinal ulcers. These ulcers were small, superficial, pigmented, and were in the colon or ileum. The overlying peritoneum was pigmented black in cases 1 and 3. The lungs in cases 1 and 3 contained hyaline pseudo-granulomata, with subpleural hemorrhages, and extravasation of blood around the pseudo-granulomata. Stained smears from the liver, spleen, lymph-nodes, rib bone marrow and pseudo-granulomata in the lungs showed numerous parasites.

DESCRIPTION OF PARASITE.

The parasite is oviform or round, and is surrounded by a clear refractile rim, which is present in all smears, whether previously treated with acid blue or not. The structure is not homogeneous, but consists of a faintly-staining substance and a deeply-staining one, a clear space or spaces, and chromatin granules. The chromatin granules are generally single; sometimes two or more are counted. One large parasite appeared to have six such dots of chromatin. The granules are often situated in a non-staining zone at one side of the dark-staining substance, at other times they are situated on the margin or within this substance, and also frequently appearing in the clear refractile capsule. The chromatin granules are generally dot shaped, very rarely elongated. Occasionally two chromatin dots are placed together simulating a rod form.

The clear space or spaces resemble vacuoles; at times they resemble the non-staining spaces seen in filaria embryos and trypanosomes. The staining substance almost entirely fills the capsule or refractile rim of the parasite. The circular contour of the staining substance is at times broken on one side by the clear non-staining zone.

This non-staining zone varies in shape, size and in its relation to the staining substance, being circular, oval or irregular in form; being three-fourths the size of the entire parasite, or at times barely perceptible on account of its minuteness; being centrally located or excentric, and being single or multiple—two or three.

In size the parasites are from one to four microns through their greatest diameter; commonly this diameter is three microns.

The parasite appears to divide by fission into two equal or unequal elements. One parasite appeared to be dividing into four equal elements. Several parasites with chromatin dots scattered through their substance appeared as pre-segmenting bodies—ready to divide into five or six elements. Occasionally a smaller parasite may be seen close beside a larger one, as though separating from it, the smaller one being about one micron in diameter.

Although oval or round in outline, the staining substance, together with the clear non-staining zone and chromatin granules, give a varying picture, depending on the point of view. Forms suggesting the appearance of familiar objects, such as the eye, a shield, a conchshell, a bullet or a shuttle, are seen. The resemblance of certain parasites to a mammalian embryo in "fetal attitude" is very striking.

Red blood corpuscles were never invaded.

Three flagellated forms were seen in a lung smear. The distal extremity of one of the flagella contained a rod of chromatin placed at right angles to the flagellum, simulating the relation of centrosome to chromatin filament in Trypanosoma Lewisi. The flagella were single, short and thick, without chromatin filaments, and were enclosed by the refractile capsule, continuous with that of the body of the parasite. The name *histoplasma capsulata* is proposed for the parasite.

MICROSCOPIC FINDINGS.

The parasite invades chiefly the endothelial cells lining the blood vessels of the spleen and liver, causing focal necroses in these organs and in the lymph-nodes draining them. The parasite apparently invades alveolar epithelial cells of pulmonary alveoli and of endothelial cells of the pulmonary capillaries, producing pseudo-granulomata and hemorrhages (focal).

The intestinal ulcer apparently is preceded by a pseudo-granuloma in the mucosa, and in my opinion the intestinal is the initial lesion; that is, the portal of entry is either through intestinal epthelium or denuded mucosa. The invaded endothelial cell is greatly distended by parasites, from 12 to 300 having been counted or estimated. The cell frequently shows no evidences of degeneration, and the invading parasite never does. The latter always takes the stain like a living or recent organism, though with difficulty at times, due, I believe, to the resistance or impermeability of the refractile envelope or capsule. The organism takes the stain well 24 hours after death of host. Maj. Ronald Ross, from an examination of my preparations, tells me that the lesions of kala-azar resemble pretty closely those found in Panama, but that the parasite is different from the Leishman-Donovan body of India,

the chief and important difference being the absence of the small chromatin rod in the Panamanian parasite.

We have, then, in tropical America a new protozoon, and to us a new disease. The protozoon has a predilection for endothelial cells, becomes encysted therein, and does not die with its host as the malarial parasite does. During one phase of its existence it is flagellated. One of my smears, taken 12 hours after death, shows flagellated forms, the flagella resembling those figured by Christopher from a citrated blood culture of the Leishman-Donovan body observed at the 11th day. The disease is a variety of tropical febrile splenemogaly associated with emaciation, and is related to *kala-azar* of India. Hitherto it has been called malarial cachexia or tuberculosis.

Quite recently I went over some of Major Ross' preparations, including one of Major Leishman's original smears. I also examined preparations of Dr. Daniels of the London Tropical School. The chief differential histopathological points are the presence of pseudo-granulomata in the lungs and the distinct focal necroses in the liver in the cases from Panama. I can find no note of these pseudo-tubercles in records of East Indian autopsies.

Until the parasite has been cultivated it may be said that morphologically it is distinctly different from the Leishman-Donovan body in not possessing the chromatin rod and in having a more complex internal structure, a greater variety to the internal arrangements of parts, and of less homogeneity in the composition of the staining substance. Up to the present I have been unable to detect the New World parasite in smears or section of ulcers and granulomata. Reasoning from analogy, it will be found, if not in Panama, then in some other region of tropical or subtropical America. Captain James' researches show that the geographical distribution of *kala-azar*, the general infection; and Oriental sore, the localized infection, is not the same. We may therefore be unable to find instances of the localized lesion in Panama. Oriental sore is common in Bagdad, the latitude of which is about that of Charleston, S. C., or Southern California. *Kala-azar* is endemic in Assam. A few cases creep into England; there is one in London now. The corresponding New World disorder is bound to appear in Baltimore some day.

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Current Literature.

REVIEW IN NEUROLOGY.

Under the Supervision of Robert Reuling, M.D., Baltimore.

A Definite Clinical Variety of Cerebral Arterio-Sclerosis. Joseph Collins. *The Journal of Nervous and Mental Diseases,* Vol. XXXIII, No. 12.

"When cerebral arterio-sclerosis occurs as a primary condition, it causes a pathognomonic clinical picture upon the existence of which alone the diagnosis is justifiable."

The symptoms that accompany it are fairly constant, and the clinical picture is not subject to much variation. The subjective symptoms are, indeed, very few, and it is with difficulty oftentimes that they are elicited. The patient complains of *fugitive* headache, often referred to the occipital region; of slight giddiness, often coupled with a sensation of insecurity of station and gait, which, however, is not attributed to the giddiness, and of impaired snap or vitality. The headache is usually dull in character, and of variable severity. In some cases it is a conspicuous feature, in others it is not. Not very often is it of an intense, agonizing character, which is fairly characteristic of arterial hypertonia, such as that occasionally occurring with mitral stenosis and aortic insufficiency. These symptoms may exist for several months, or even years, before other and more striking symptoms occur. The emotional symptoms, which occasionally are early manifestations, are attacks of meaningless laughter, less often crying, which do not occur in the spasmodic form that is sometimes seen in disseminated sclerosis or in ancient apoplexies, but which are like them without emotional concomitant. The most striking feature of the disease, however, is the patient's appearance. The individual becomes transformed from a person expressing grace in movement and relaxation in repose into an immobile, inanimate replica of the normal person. The immobilization gives a characteristic attitude and gait, and to a lesser degree a characteristic physiognomy. The gait is, perhaps, the most remarkable feature of the patient. (See illustrations). The stride is short, oftentimes only a few inches; the feet widely separated and not lifted far from the ground, the rythm of the movement often slow, but sometimes rapid. In some instances, perhaps in all, the patient can run better than walk. Mental symptoms may or may not exist. In the majority of cases they are not conspicuous, consisting merely of some depression, indifference and apathy. At first sight the clinical picture reminds one of Parkinson's disease, but on close observation they have only one feature, immobilization, in common. There are no vasomotor symptoms and secretory symptoms, no marked alteration in the pitch of the voice, no characteristic tremor, no festination or other striking feature of the latter disease. The knee-jerks are usually

lively, and in some cases that have lasted a long time the big-toe phenomenon of Babinski is present, indicating secondary degeneration in the pyramidal tracts of the spinal cord. In some cases there is evidence of sclerosis of the skeletal and visceral arteries, but in others, perhaps the majority, there is slight involvement of them. Indeed, the blood pressure as revealed by the sphygmomenometer may be below 110-130 (S.), and the heart sounds divided by particular change. One of the most remarkable features of the disease is the occasional complete absence of visceral and skeletal arterio-sclerosis. In private practice, patients thus afflicted are often looked upon as hysterical or neurasthenic individuals, while in hospitals, especially those given over largely to patients suffering from chronic disease.

* * *

Theoretical and Practical Consideration of Head's Zones in Visceral Disease. Kast. (*Berlin klinische Wochenschrift,* 1906, XLIII, 1033.)

Head claimed to have demonstrated that certain areas of increased sensitiveness to pain and heat sensation in the skin corresponded definitely to disease of various viscera. The zones, he claimed, corresponded to different spinal segments, and do not follow the distribution of the peripheral nerves. Their mode of origin he assumes is, so to speak, a psychical deception. We are devoid of pain sensation conveyed directly from the internal organs, but the sensory nerves running from the skin and our subjective sensations may interpret impulses in the one as pain sensations in the other referred pains. Kast is of the opinion that in many instances there is hypersensitiveness, so that impulses which, under ordinary circumstances are not painful, are interpreted as such. This condition Kast terms a local neurasthenia. He also points to the importance of recognizing the general instability of the nervous centers in the development of the hyperesthetic areas. They are certainly better defined in neurasthenic individuals. In a normal person the continuous discharge of centripetal impulses from the internal organs runs to the center, but whatever changes they produce their effects remain in the subconscious sphere. Under conditions of increased sensitiveness to external and internal stimuli (neurasthenia), these impulses enter the conscious sphere and are frequently transformed into painful sensations. Lenander has shown that one may handle or insult in various ways the abdominal viscera without producing pain sensation; that pain sensation can be evolved only from the perietal peritoneum. This explanation of the hyperalgesic skin areas is the interstitial inflammation about and through the spinal nerves caused by a lymphangitis spreading from the diseased organ. Kast takes exception to such a view, urging that the skin zones do not follow the distribution of the spinal nerves, and that, if such a perineuritis existed, it would give rise to severe neuralgic pains.

As interesting as the discovery of Head's zones are, they have

not proved of great practical value. In the first place, their occurrence is not constant. They are frequently present in gastric ulcer, particularly in anemic nervous patients, and in instances of much pain. But in some of the most evidence cases they are absent. The same is true of appendicitis and cholecystitis. In 12 cases of gastric carcinoma, all associated with a great deal of pain, Head's zones were present on only one.

* * *

THE MODE OF CONNECTION OF THE MEDULLATED NERVE FIBERS WITH ITS CELL BODY. By Oliver S. Strong. *The Journal of Comparative Neurology and Psychology*, November, 1906, Vol. XVI, No. 6.

"One of the principal lacuna in our present knowledge of the finer structure of the nervous system concerns the medullated and non-medullated portions of the nerve fibers—our ignorance of precisely what parts are medullated and what are not. This has been brought out by Nissl in his book on the Neurone Theory, and while Nissl is doubtless over-exacting in his requirements as to what is necessary to practically establish neuro-histological relations, yet he has done a service in calling attention to the somewhat surprising lack of actual observation on certain relations which have been taken more or less for granted. The principal terra incognita is, naturally, that portion of the distal end of the nerve fiber extending from where the sheath ends to the pericellular termination. There is also some deficiency in an actual observation regarding the proximal end of the fiber, especially its acquisition of the sheath."

As Strong points out, the difficulties which confront the solution of this histological problem are defects of our present histological technique, for we still lack a practical specific axis cylinder stain. "We also lack a good method of combining these two pictures and demonstrating at once the medullated and non-medullated parts of the nerve fiber. The present note does not profess to furnish such a method, nor to fill in the most important of the gaps above mentioned, but simply to give some demonstration of the relation of the medullated fiber to its all origin. These are taken from preparations made by means of modifications of the Wiegert-Pal method, which have so far proved rather uncertain and limited in their applicability, but are nevertheless here given.

The lumbar cord of an infant five weeks old was used, previously preserved in a 10 per cent. formalin (4 per cent. formaldehyde). Pieces five millimetres long were placed in a neutral developer (aortal without alkali being the one actually used) for two days, then transferred to copper bichromate 2 to 3 per cent. for two days, then dehydrated, embedded in colloidin and cut. The sections were stained in 1 per cent. aqueous hematoxylin solution 12 to 24 hours, and decolorized in potassium permangenate and weak sulphurous acid in the usual way. Various modifications and decolorizing schemes were used by the author, and the reader is therefore

referred to the original article for more intimate knowledge of these.

The "axone cone" emerging from the cell body or from a dendrite usually either tapers regularly to the marrow portion of the axis cylinder process, or first diminishes gradually and then more abruptly. The curves described are so similar to those produced by pulling apart some plastic substance as to suggest that a tension upon this, presumably the weakest, part of the axis cylinder may have been a factor in its production either during growth or as an artefact in fixation, or both. In some preparations, this portion is still thinner than indicated in the accompanying figures. Often, too, the cone and the medullated part of the fiber are shown, this intervening portion not being visible. This is probably due to its being decolorized. This extreme attenuation is not improbably an artefact. It is hardly probable, however, that all of the diminution in thickness of this portion of the axone is *artificially* produced, inasmuch as it has been demonstrated by so many methods (Golgi, Ehrlich, Cajal).

Beyond the narrow portion the axone expands, and at the same place becomes medullated (axis cylinder). This expansion may be rather gradual or quite abrupt. At the same time there is usually an apparent deepening of the stain. This is probably due partly to the increase in size and partly to presence of the stained myelin sheath above and below the axis cylinder. Considering the well-known tendency of the axis cylinders to shrink, they would appear to be fairly well fixed in these preparations.

The increase in size of the axone always coincides with the appearance of the myelin sheath. There seems to be often a correlation between the mode of expansion and the appearance of the sheath. When the former expands abruptly, the sheath appears to attain its full size also abruptly.

REVIEW IN SURGERY.

By William A. Fisher, M.D., Baltimore.

PAPILLARY CYSTADENOMATA OF THE BREAST.

Greenough and Simmons (*Annals of Surgery*, February, 1907) open their paper with a presentation of Warren's classification of benign tumors of the breast, in which a distinction is made between the diffuse tumors or hyperplasia and the encapsulated or fibro-epithelial tumors. The papillary cystadenomata compose a group of tumors of the fibro-epithelial class in which the epithelial elements predominate.

These tumors consist of one or more cysts partially filled with papillary outgrowths from the wall, and as they usually involve the large ducts they are commonly found close to or under the nipple. The contents of the cysts consist of a sanguinous or bloody fluid. They are well encapsulated, and not adherent to the skin unless the tumor becomes very large. In 20 cases examined adeno-carcinoma was found three times. In two of these cases the

nipple was retracted. This condition was also noted in three of the non-malignant cases, produced perhaps by the development of a benign tumor in the large ducts, causing a drag upon them and retraction of the nipple.

Microscopically, these cysts presented a fibrous wall, with evidences of compression of the surrounding breast tissue. The lining membrane consists of one or more layers of duct epithelium, which is continuous with the proliferated epithelium covering the papillary masses. The stroma of these papillary masses is composed of fibrous tissue carrying blood vessels and attached in one or more places to the cyst wall.

These tumors occur, as a rule, past middle life, the average age in the 20 cases reported being 49.5 years. There does not seem to be any definite connection with marriage and lactation. Trauma was given as a cause in only five cases.

In the majority of cases the symptoms are well defined. A round tumor, varying in size from a pea to an orange, is found in the central portion of the breast near or under the nipple. On palpation the mass is elastic or may give the sense of fluctuation. Pain is present in about one-half the cases, but is not so severe as in the cystic breast. The most valuable symptom is a bloody discharge from the nipple. This was present in 11 of the 20 cases. In some cases it may be forced from the nipple in sufficient quantity to reduce the size of the tumor. Enlargement of the axillary glands is usually absent even in the cases of carcinoma.

The diagnosis is facilitated by three chief symptoms—(1) the situation, under or close to the nipple; (2) the slow, painless growth; (3) the presence of a discharge from the nipple of a bloody fluid.

These tumors can be differentiated from cancer by their slow growth, definite outline and lack of involvement of the skin, subjacent tissues and axillary glands.

In abnormal involution the changes are usually found in the periphery of the breast; the mass is more diffuse and irregular and of a more nodular consistence. Pain is more often present and more severe.

In periductal fibromata the tumors are more likely to be multiple, situated in the periphery of the breast, firmer and more elastic. There is never a discharge from the nipple. They occur in younger subjects.

The prognosis in these tumors may be said to be good, for they may exist for a long time without giving inconvenience, and do not recur when thoroughly removed. Carcinoma has developed in 15 per cent. of the cases, but is of a benign character (adeno-carcinoma), in which the axillary glands are not involved until late. Of the three cases of carcinoma, only one died of recurrence—a very good showing in view of the fact that the axilla was dissected in only two cases. The fact that carcinoma occurs in 15 per cent. of cases is sufficient to warrant the complete removal of these tumors early.

When the tumors are large or multiple, amputation of the breast may be necessary, but when possible excision of the tumor alone may be done by "plastic resection," as described by Warren, or by an incision following the lower border of the areola. When the latter incision is used it is drawn apart with retractors in a direction radiating from the nipple and the tumor excised without injury to the ducts.

The results of studying these 20 cases may be partly summarized as follows:

1. They are single or multiple tumors, situated near or beneath the nipple, composed of one or more cyst cavities, from the walls of which grew papillary outgrowths.
2. They occur at all adult ages and independent of trauma, marriage or lactation.
3. They are usually painless.
4. Their most characteristic symptom is a bloody discharge from the nipple.
5. Fifteen per cent. of the cases were associated with adenocarcinoma.
6. Treatment demands complete removal of the tumor either by excision or amputation of the breast when necessary.

* * *

SENILE PARENCHYMATOUS HYPERTROPHY OF THE FEMALE BREAST—ITS RELATION TO CYST FORMATION AND CARCINOMA.

After discussing the various physiological changes which take place in the female breast during its development and the various benign new growths found in the young adult breast, Bloodgood (*Surgery, Gynecology and Obstetrics*, December, 1906) comes to a consideration of senile parenchymatous hypertrophy.

This lesion is described under many terms by different authors—in France as the "Maladie de Réclus," in Germany as Schimmelbusch's disease, and Warren in this country has recently given it the term of abnormal involution. This disease is met with most frequently between the ages of 40 and 50 and in women who have not borne children and who have not lactated. In women who have lactated there is usually an interval of at least 10 years between the last lactation and the first symptoms of the disease. This disease presents itself in two stages—the benign and the malignant. In the former there are two types: I. Cystic. In this form one may find in one or both breasts one or more smooth-walled, medium or large sized cysts, which may arise at any stage of the disease. In these cases carcinoma is very rare, and simple excision of the cyst wall is justifiable. The cystic change begins as a dilation of the ducts and acini, which are filled with a greenish fluid containing débris of disintegrated cells. Gradually as the dilation increases large cysts are formed, the walls of which consist only of fibrous tissue, the epithelial lining having disappeared as a result of pressure. This may account for the rarity of carcinoma in these cases. II. Adenocystic. In this form one finds localized enlargement in one or both breasts, but large cysts are never found. Adeno-

carcinoma is found in about 50 per cent. of these cases, and for this reason it would seem best to remove the entire breast. This carcinomatous change can be recognized by the increase in consistency of the area and by its more granular appearance. Microscopically, one sees in these adenocystic areas dilated ducts and acini, some of them filled with fluid, others containing proliferating epithelial cells, often arranged in a papillomatous form. Bloodgood sees an analogy between the different stages of this disease and those of prostatic hypertrophy, pointing out the frequency with which carcinoma of the prostate is associated with the adenocystic form of prostatic hypertrophy.

* * *

REPORT ON THE TRYPSIN TREATMENT OF CANCER.

Graves (*Boston Medical and Surgical Journal*, January 31, 1907) gives his results of trypsin injections in four cases of recurrent carcinoma of the breast. He has selected these recurrent cases for the following reasons: 1. All that could be done surgically had been done; 2. They were in good general health; 3. The effect of trypsin on the nodules could be seen; 4. On account of their superficial situation they could be readily excised for microscopic examination.

Injectio trypsini of Fairchild was used, beginning with 10 minims, increasing to 40 or 60 minims three times a week. If the larger doses are used, it is preferable to divide them and inject several areas. Severe constitutional disturbances were noticed in only one case, and then only with the first injection. In this case the symptoms were similar to those noted when Coley's fluid is used, but more severe. There is a constant local reaction in the form of a red, hard, tender swelling, which, however, does not go on to suppuration, and quickly disappears after the injections are discontinued. In one case two nodules that had been treated by trypsin injections were excised and studied microscopically. One, which had been repeatedly injected, consisted of dense fibrous tissue and a great deal of small round-cell infiltration, but no cancer cells could be made out. In the other, which had been injected only once three days before excision, cancer cells were present, but they were swollen and faintly stained, and comparing them with those in the original tumor, seemed to be in a state of degeneration.

The connective-tissue cells and small round cells, on the other hand, appeared normal, thus bearing out the statement of Beard that trypsin does not affect the somatic cells. This case has remained about the same. Another case which was operated upon a second time has been having injections for four months, and is free from recurrence at the present time.

Two cases were not benefited, except that one was relieved of pain apparently by the injections. In the author's experience direct injections into carcinomatous nodules have resulted in a shrinkage or disappearance of the growth, but at the same time other nodules may appear in close proximity, so that he concludes that carcinoma is not affected by trypsin in the circulating blood, but only by direct contact with it.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

NOTICE.

THE annual meeting of the State Faculty will be held on the 23d, 24th and 25th of April. Members desiring to present papers must send title *before April* 10 to Dr. A. P. Herring, chairman of the Committee on Scientific Work and Arrangements, 1317 Madison Avenue, Baltimore.

THE meeting of the Baltimore City Medical Society, prior to the annual meeting of the Medical and Chirurgical Faculty, will be held at the hall, 847 North Eutaw Street, on Tuesday evening, April 2, 1907, at 8.30 P. M.

Dr. Edsall of Philadelphia and Dr. I. S. Stone of Washington will read papers, and business of importance relating to the City Society will be discussed.

Members are requested to consult their monthly bulletin for the completed program.

Election of new members will be held and applications accompanied by $5.00 will be received by the Board of Censors as late as 8 P. M. on the night of the meeting. Application blanks may be obtained from the Librarian, the Secretary, W. E. Magruder, or from the chairman of the membership committee, J. A. Chatard, or will be mailed upon request.

It is the desire of the officers and Board of Censors that every reputable physician in the city be requested to join the organization.

The fee of $5.00 must accompany the application and entitles the physician, if elected, to membership in the Baltimore City Medical Society and its various sections, to the Medical and Chirurgical Faculty, use of its extensive library, to free subscription to Maryland Medical Journal and to protection against suits for malpractice.

SOME FACULTY FEATURES OF GENERAL INTEREST.

THE pages of the JOURNAL devoted to Faculty material have been so filled with articles which it was necessary to print that it has been impossible, until the present time, to call attention to several matters which should interest the profession at large. It is with great pleasure that we mention several recent innovations which should be used to be appreciated.

The most important of these, and one which everyone should know, is the arrangement which the Library Committee has made with several publishers of medical works to have the new books sent on approval to the library, where they will be kept for the benefit of the profession in a special case which has been provided for the purpose. The reasons for having books so sent will appeal to everyone. In the first place, it enables the Library Committee and others interested to inspect all the new American publications and so to make intelligent choice of these for the library shelves. Doubtless many more books will be purchased when once they are seen and their merits appreciated. Secondly, it enables the members of the profession to see what to buy for themselves and what they do not want. Many men have no time in which to go from shop to shop seeking out an opportunity to look at the new books, and so the possibilities for enlarging one's library depends largely on itinerant agents or the advertising columns of the various medical journals, neither one of which can be said to be infallible guides.

Every two months new books will be received from the publishers and placed in the special case. These will be at the disposal of the visitors to the library. After the two months are up the volumes purchased by the Library Committee will be placed in the accession case, where they will remain for the customary period, after which they may be taken from the library by readers. By making a short visit to the library once a month anyone can easily see what books are being placed on the market by American publishers and can get a very fair idea of the progress in the various departments of medicine. If any recent publication is not on the shelves of the library, and if it has not been on exhibition, an effort will be made to secure it.

The members of the profession who use the library, and those who are interested in its welfare, are requested to send to the Library Committee the names of any books which they may desire to have purchased. Every effort will be made to have the best of these bought for the library, but as the number of publications is very large and the funds of the committee small, only books for which there is a demand can be placed on the shelves. These are not chosen for any class of readers, but as far as possible for the use of the profession at large.

Another innovation is a bulletin board, on which will be posted operations and clinics, which will be of interest to physicians visit-

ing in the city. It is the desire of the Faculty to have at the library a bureau of information, where one may ascertain what is going on in town in a medical and surgical way. To make this a success the co-operation of the staffs of the various hospitals has been asked, and it is earnestly requested that notices of the desired character be sent in at regular intervals.

A visitors' register has also been procured, so that a list of the out-of-town visitors may be kept. This is done in all clubs and institutions like the Faculty, and will prove of great interest to all concerned.

Lastly, everyone knows that the greatest need of the Faculty is a new library building. The reasons for this are so apparent that it would scarcely seem necessary to mention them. A committee on a new building has been appointed and will take immediate and active steps to secure funds with which to erect a suitable building. A certain amount of money is already in sight, but a great deal more remains to be collected, and every member of the Faculty should take an active interest in this work. Each physician should contribute as much as he is able and should induce his friends and patients to contribute. Announcements of the plans of this committee will be made at a very early date, when the reasons for a new building will be set forth, together with the methods used for getting money for new library buildings in other cities. New York, Boston, Brooklyn, Hartford, Philadelphia and other cities have their precious medical libraries housed in fireproofed buildings, and we should not lag behind, leaving our collection of books, many of which it would be impossible to duplicate, in a regular firetrap of a building.

THE McCORMACK MEETINGS.

THE meetings held on the 28th of February last under the auspices of the Faculty were noteworthy in many respects. The fact that the American Medical Association finds it advantageous to "keep on the road," if a commercial expression is allowable, such a man as Dr. McCormack, and that he is welcomed everywhere by the profession and public, are in themselves striking. They mean that the trustees of the association, numbering in its membership the leaders of medical thought, and coming in contact in all the States with professional opinion, have found a general need for instruction on some of the essentials of medical life; that physicians are ready to receive instruction and respond to it, and that the instructor selected is admirably suited for the task. That "medical organization" would logically lead to the need of closer relations between the public and profession has been clear for some years. That the public is ready to meet us was demonstrated everywhere Dr. McCormack went, notably in Baltimore. The large and appreciative audience which greeted him at McCoy Hall afforded ample testimony that people are interested in medicine, when properly presented, while the address proved the possi-

bility of saying some very plain and useful things, so that everybody can understand just what is meant, and yet without the least offense to good taste.

At the meeting in the afternoon at the Faculty Hall the speaker devoted himself largely to showing the reasons which, in his opinion, account for the little influence of the medical profession in public affairs. "Bar and press associations," he said, "dominate public opinion." Why? Because, in the opinion of the speaker, "doctors are such pastmasters in the art of vituperation"; because the public, while trusting the individual doctor in cases of illness, has little confidence in him "collectively." This he traced to ungenerous suspicion and frequently totally unjust criticism of one another. While medical men, in awe of traditional ethics, or through fear of professional criticism, hold back opinions upon matters they are capable of talking about—matters about which the public wants and ought to know—they are free enough in indulging in more or less criticism of each other's methods and motives, and express themselves in places and under circumstances calculated to give these criticisms wide publicity. How is it possible, he asked, for the public to retain a higher opinion of us than we do of each other? How, indeed? The vital question is how correct are the premises? He thought that "medical schools are the hotbeds of professional dissensions." He described vividly the free and easy way in which the faculty of one school hauls over the coals that of another, and showed the effect on young medical men who listen to these things. Physicians will interpret these statements according to their own observations and environment. Yet the question is full of importance. Are the graduates of our schools turned out with a poor or prejudiced opinion of the men in other schools, whose graduates they are to meet in daily life? Is there a "provincial" atmosphere about each school, cultivated not for the sake of increasing interest of alumni in their alma mater, but of making them look askance at men in other institutions? Are they started in a life which requires "fraternal" relations among its members with just the opposite spirit, inculcated by four years of talk and example? It is the *spirit* which will follow them, and if this is wrong it must be changed. The question presented by Dr. McCormack is one which teachers should ponder carefully. A man who has seen more of the profession than probably any other one man, who has come in contact with his professional brethren in cities, towns, villages, country stores and everywhere, who has the ability, evidently possessed by the Doctor, to look beneath the surface and see things as they are—such a man is apt, if free from prejudice, as, we believe, Dr. McCormack is, to be right, or nearly so. If he has traced professional discord to its source, a remedy should easily be found.

There will be less disposition to question Dr. McCormack's sec-

ond indictment against medical men. He thinks they have less influence in public affairs than lawyers, because the latter are constantly rubbing shoulders against each other. The nature of their work brings them into contact with their professional peers, and so they avoid that dogmatic, arbitrary mental state so often seen in men of our calling. One cannot help recalling an address delivered in Baltimore some years ago by Dr. Osler upon the advantages of medical societies. He compared the physician who is a society man with his brother who "has no time for such things." He showed how the latter, with the patient hanging on his words, relatives sitting around listening to his oracular utterances, nurse ready to do his bidding, and none able to say whether he is handing out the real thing or not, can easily develop a spirit of arrogance and narrowness which render him incapable of taking a broad, public view of anything. Dr. McCormack, as had Dr. Osler, demonstrated the place of the medical society as an antidote and prophylactic for this sort of mental imbalance. And both men are right. Other matters touched on in the address to physicians were the medical society as a post-graduate school and bureau of public medical instruction, necessity for school instruction in medical ethics and medical business. "If certain things are dishonest for a physician and surgeon in post-graduate life, why not teach him so during his student life?" Expert testimony, relation of the profession to the press, suppression of quackery and means of enlisting the aid of the press in this fight were discussed. The address was listened to for the hour and a half it consumed with absorbed attention from the audience, which crowded the hall to its utmost.

At McCoy Hall in the evening His Excellency Governor Warfield presided. Prevention of preventable diseases and the duty of "nice people thinking about things that are not nice and quitting doing them" was a theme on which Dr. McCormack dwelt at length. His presentation of the drug store prescribing department, with its indirect encouragement of immorality; the results of ignorance among boys and girls concerning matters their parents should tell them about, was masterly. At the close of his address the Governor, who was compelled to leave, expressed deep appreciation and invited Dr. McCormack to come again and visit other parts of the State. It is to be hoped he will, for what he said is what needs to be said, and no greater field of usefulness is open to organized medicine than this of public instruction. Mr. Joseph Packard, president of the School Board, spoke of the ignorance of the poorer classes in matters of ordinary hygiene and the necessity of enlightening them. Rev. Dr. Hussey pressed home upon the audience the importance of some of the things presented in the main address, especially the need of parental instruction. Mr. John Glenn, who was to speak from the standpoint of organized charity, did not do so, as the hour was late. H. W.

REPORT OF THE MEETING OF SECTION ON CLINICAL MEDICINE AND SURGERY.

FRIDAY, FEBRUARY 1, 8.30 P. M.

Chairman: C. U. Smith. Secretary: H. G. Beck.
Third Member of Executive Committee: J. A. Chatard.

AN EXPLANATION OF THE NARCOTIC LAW UNDER WHICH THE PROFESSION IS NOW WORKING.

W. Edward Magruder, M.D.

At a special meeting of the Baltimore City Medical Society, held prior to the last session of the General Assembly of Maryland, a committee, composed of Drs. Earle, Linthicum and myself, was appointed for the purpose of aiding in securing the passage of the Godwin bill, regulating the labeling and sale of proprietary and patent medicines.

Circular-letters were sent to the medical societies in the various counties, to the physicians in this city, and to influential laymen and ministers asking their support and co-operation. Members of the committee and other interested physicians made addresses before various clubs, church societies and improvement associations, and a large general meeting was held in McCoy Hall for the purpose of creating public sentiment in favor of the bill.

A joint meeting between this committee of physicians and one appointed by an association of druggists was also held with the idea of joining forces and going before the committee of the House of Delegates as representatives of the two professions.

It soon became apparent to our committee that the Godwin bill, which we were supporting, was too drastic for the majority of druggists, was grossly misunderstood by others, and was bitterly opposed by the proprietary-medicine representatives, of whom quite a number were found to be members of the Druggists' Association.

The joint committee held a meeting on the train to Annapolis and agreed upon a modified bill which they believed would be satisfactory to the interests which they represented. This bill was presented through Mr. Godwin, but, owing to strenuous work on the part of the proprietary-medicine interests and those druggists whose views did not accord with those of their committee, the bill was reported unfavorably by the House Committee on Hygiene, before whom we had our hearing.

But as a result of the work of this committee public sentiment was created in favor of some legislation against the indiscriminate sale of patent and proprietary medicines, whose composition is known only to the manufacturer; and while we were preparing to introduce another bill, the opposing factions secured the passage of the present Maryland Antinarcotic Law, effective June 1, 1906.

While this law places strictures upon the retail druggist and controls the prescriptions containing certain drugs written by physicians, it fails to curtail the privileges of the patent and proprietary medicine manufacturers to any marked degree. Fortunately,

however, the Federal Pure Food and Drug Law requires the percentage of certain injurious drugs to appear upon the label, and thus materially reinforces the present Maryland Antinarcotic Law and gives us increased protection, although not directly controlling those preparations manufactured and sold within the State.

After talking to many physicians and druggists, I found that some appeared never to have heard of the Maryland Antinarcotic Law; others knew of it, but did not understand it, and still others—and of these, I regret to say, the number is large—had not been awakened to the importance of complying with its provisions.

The great advantages of this law and the chances for strengthening it by future legislation can be enjoyed only through having it thoroughly understood and enforced.

For this reason I desire to call the attention of physicians to the fact that we have such a law, capable of working great good, and ask their observance of it.

As applied to physicians, the law requires the name and address of the patient and the date of writing to appear upon each prescription containing any cocaine, eucaine, opium, morphine, heroin, chloral hydrate, or any of their salts or compounds, and forbids the druggist to furnish a copy of or refill this prescription except upon the written order of the original prescriber.

It is easy to see how this may work a hardship upon a conscientious druggist when he declines to repeat a prescription without the physician's written order. If, however, the attending physician has previously stated to the patient that he has written for a certain definite number of doses of a preparation, and that he will have to write a new order if it becomes necessary to continue the drug beyond the time originally provided for, all trouble may be prevented.

The pecuniary advantage to the physician of the compulsory return of his patient for a new prescription is worth considering even though he may be oblivious to the fact that drug habits may be formed for which he is often largely responsible.

While we all resented the statement made by a Baltimore druggist at Annapolis in opposition to the bill we had been advocating that physicians are directly responsible for the production of a large majority of drug fiends, I fear it is in a great measure true. I was gratified to have this same druggist prove to be the first to return one of my patients to me for a new prescription after the Antinarcotic Law went into effect, arousing me to a realization of the existence and scope of the law.

By keeping the important features of this law in our minds we may be able to co-operate with the druggists in its proper enforcement and thus enable the public to profit by its provisions.

I will pass around copies of the law for your inspection:

An Act to repeal Chapter 607 of the Acts of 1904, and to re-enact the same with amendment.

SECTION 1. *Be it enacted by the General Assembly of the State of Maryland,* That it shall be unlawful for any person, firm or corporation to sell,

furnish or give away any cocaine, eucaine, opium, morphine, heroin, chloral hydrate, or any salt or compound of any of the foregoing substances, or any preparation or compound containing any of the foregoing substances, or their salts or compounds, except upon the original written order or prescription of a lawfully authorized practitioner of medicine, dentistry, or veterinary medicine, which order or prescription shall be dated and shall contain the name of the person for whom prescribed, or if ordered by a practitioner of veterinary medicine shall state the kind of animal for which ordered, and shall be signed by the person giving the prescription or order. Such written order or prescription shall be permanently retained on file by the person, firm or corporation who shall compound or dispense the articles ordered or prescribed, and it shall not be again compounded or dispensed, except upon the written order of the original prescriber for each and every subsequent compounding or dispensing. No copy or duplicate of such written order or prescription shall be made or delivered to any person, but the original shall at all times be open to inspection by the prescriber and proper authorized officers of the law.

Provided, however, that the above provisions shall not apply to paregoric and laudanum, or to bona-fide proprietary medicines containing codeine, or not more than two grains of opium, or not more than two-fifths grain of morphine, or not more than one-fourth grain of heroin, or not more than 10 grains of chloral hydrate, in one fluid ounce, or if a solid preparation, in one avoirdupois ounce. Provided also that the above provisions shall not apply to preparations containing opium and recommended and sold in good faith for diarrhea and cholera, each bottle or package of which is accompanied by specific directions for use, and a caution against habitual use, nor to powder of ipecac and opium commonly known as Dover's Powder, nor to liniments or ointments when plainly labeled "for external use only."

And provided further that the above provision shall not apply to sales at wholesale by jobbers, wholesalers and manufacturers to retail druggists, general merchants, or qualified physicians, or to each other, nor to sales at retail by retail druggists, general merchants, to regular practitioners of medicine, dentistry or veterinary medicine, nor to sales made to manufacturers of proprietary or pharmaceutical preparations for use in the manufacture of such preparations, nor to sales to hospitals, colleges, scientific or public institutions.

SEC. 2. It shall be unlawful for any practitioner of medicine, dentistry, or veterinary medicine to furnish or prescribe for the use of any habitual user of the same any cocaine, heroin, alpha or beta eucaine, opium, morphine, chloral hydrate, or any salt or compound of any of the foregoing substances, or any preparation containing any of the foregoing substances or their salts or compounds. And it shall also be unlawful for any practitioner of dentistry to prescribe any of the foregoing substances for any person not under his treatment in the regular practice of his profession, or for any practitioner of veterinary medicine to prescribe any of the foregoing substances for the use of any human being.

Provided, however, that the provisions of this section shall not be construed to prevent any lawfully authorized practitioner of medicine from furnishing or prescribing in good faith for the use of any habitual user of narcotic drugs who is under his professional care such substances as he may

deem necessary for their treatment, when such prescriptions are not given or substances furnished for the purposes of evading the provisions of this act.

SEC. 3. Any person who shall violate any of the provisions of this act shall be deemed guilty of a misdemeanor, and upon conviction for the first offense shall be fined not less than $25 nor more than $50, and upon conviction for a second offense shall be fined not less than $50 nor more than $100, and upon conviction of a subsequent offense shall be fined not less than $100 nor more than $200, and shall be imprisoned in jail for not more than six months, and if a licensed pharmacist, physician, dentist or veterinary surgeon, his license shall be revoked, half of the fines to go to the Maryland Board of Pharmacy for prosecuting this law. It shall be the duty under this act of all judges of the courts having criminal jurisdiction in this State, at every regular term thereof, to charge all regularly impaneled grand juries to diligently inquire into and investigate all cases of the violation of the provisions of this act and to make a true presentment of all persons guilty of such violations. It shall be the duty of the Maryland Board of Pharmacy to cause the prosecution of all persons violating the provisions of this act. No prosecution shall be brought for the sale of any patent or proprietary medicine containing any of the drugs or preparations hereinbefore mentioned until the Maryland Board of Pharmacy shall certify that such medicine contains any of the said drugs or preparations in excess of the maximum percentages hereinbefore mentioned.

SEC. 4. In any proceedings under the provisions of this act the charge may be brought against any or all of the members of a partnership, or against the directors or executive officers of a corporation, or against the agent of any person, partnership or corporation.

SEC. 5. And be it further enacted, that all criminal proceedings pending, or which may be hereafter instituted for offenses already committed, shall be instituted, proceeded with and prosecuted to final determination and judgment as if this act had not been passed.

SEC. 6. All laws and parts of laws that conflict with this act are hereby repealed.

SEC. 7. This act shall take effect and in force from and after the 1st day of June, 1906.

INTESTINAL OBSTRUCTION.

Joseph C. Bloodgood, M.D.

Stimulated, probably, by some interesting recent cases, I felt that a careful clinical and pathological investigation of the experience of Dr. Halsted's clinic of the Johns Hopkins Hospital, of intestinal obstruction, would at least be valuable to myself. It proved to be of such interest that I presented some of the conclusions before the New York State Medical Society in Albany January 30, and do not hesitate to repeat them again tonight.

The conclusions in regard to the importance of early intervention in all cases and the life-saving measure of enterostomy in late cases I find is confirmed by Rubritius (*Beiträge zur klin. Chir.*, 1906, Vol. LII, p. 405) from Wölfler's clinic in Prague, by Simon

(*Beiträge zur klin. Chir.,* 1905, Vol. XLV, p. 489) from Czerny's clinic in Heidelberg, and by Göbell (*Deutsche Zeitschr. f. Chir.,* 1906, Vol. LXXXII, p. 416) from Helferich's clinic in Kiel.

Intestinal obstruction should be employed as a general term, and corresponds to the German term "ileus." All authorities recognize two groups—*strangulation ileus,* in which, in addition to obstruction to the lumen of the intestine, there is interference with the mesenteric blood supply, and *obturation ileus,* in which the blood supply of the obstructed portion of the intestine is not disturbed. In some cases the intestinal obstruction may begin as an obturation and end as a strangulation.

It is quite true that in obturation ileus the patients may survive a longer period from the onset of the symptoms to the time of operative relief. Nevertheless, in either group immediate surgical relief gives the best results.

The older view favoring delay in obturation ileus is emphatically discredited by all recent contributions. Intestinal obstruction from its onset should be looked upon as a surgical lesion. No conservative means should be employed for its relief except the washing out the stomach and high rectal enemata. These should be used only in the early hours, and if relief is not immediate the abdomen should be opened. Any food, liquid or solid, or cathartics by mouth, is absolutely contraindicated from the moment of the first symptom until the patient is relieved. Morphia should not be given for the pain unless operation has been decided upon.

These rules, simple as they may appear, have seldom, if ever, been followed in patients admitted to surgical clinics. In the three contributions from the German clinics just mentioned and in many other articles on special forms of ileus the writers call attention to the delay after which these patients are referred to the surgical clinic and to their previous drastic treatment with cathartics, and the masking of the symptoms with large doses of opium.

I found the same to be true in a series of cases admitted to the surgical clinic of the Johns Hopkins Hospital.

Intestinal obstruction is a relatively infrequent disease. Among about 20,000 patients admitted to the surgical clinic I find but 103 instances of ileus; rarely have two of these cases come from the practice of the same physician.

The general practitioner, therefore, will be called upon to attend this lesion only at rare intervals. It should be the duty of surgical clinics, whose collective experience is so much larger, to instruct the physician on the symptoms of onset and to demonstrate to him by irrefutable figures that his patients' chances are tremendously increased by operative interference—if possible within the first 24 hours, at least before the end of the second day. The more acute the symptoms of onset the more immediate must be relief. It is fortunate that in strangulation ileus, in which the earliest intervention is required, the symptoms of onset are most acute and characteristic, while in obturation ileus the clinical picture is more obscure, requiring a few days to make the diagnosis. Fortunately,

if the delay of relief is not too long, the chances of recovery are good.

Surgeons are in a better position than physicians to study the early clinical picture of intestinal obstruction. After every laparotomy this complication must be borne in mind. All postoperative patients receive unusually critical investigation if any symptoms suggestive of obstruction arise. That surgeons have become more expert in the diagnosis is borne out by the fact that in Dr. Halsted's clinic and in observations of my own in other hospitals postoperative intestinal obstruction has been recognized early, and the mortality is strikingly less than in the group of patients first observed outside the clinic and then referred for operative treatment. It is due, then, to this fact that one feels justified in speaking so emphatically to the general practitioner.

In strangulation ileus there are two factors which give rise to symptoms—obstruction to the flow of intestinal contents and interference with the circulation of the obstructed intestine. It is the interference with the blood supply that gives the acute symptoms of onset in strangulation ileus—the intense pain, the peritoneal shock, and the primary reflex vomiting. Secondary vomiting, fecal in character, distention, are symptoms due to the obstruction, and may be looked upon as late symptoms—symptoms which one should not wait for in order to make a diagnosis. In obturation ileus the symptoms of onset present in strangulation are usually absent. The patient may complain of some abdominal pain, which is described more as a general discomfort than acute agony. It is constipation that first attracts his attention, then distention, then vomiting, which may, in delayed cases, be fecal in character.

It is frequently difficult to explain the exact cause of pain and its acuteness in a strangulation ileus. We know that the intestine is insensitive. One interested in the sensitiveness of the peritoneum and abdominal viscera and the explanation of intestinal colic should read Lennander's (*Mittheilungen aus d. Grenzgeb. d. Chir. u. Med.*, 1906, Vol. XVI, pp. 19 and 24) and Wilms' (*Ibid.*, 1906, Vol. XVI, p. 609) recent communications. There is no question as to the pain in strangulation ileus, and apparently it is not due in its onset to increased peristalsis. It is probably explained by the pull on the mesentery or the interference with its blood supply, which affect the sensitive nerves at the mesenteric base. For example, I have seen a number of instances of strangulated inguinal or femoral herniae of the Ritter variety. Here the wall only of the gut is caught. These patients complain very much less of pain than those in which the mesentery participates in the strangulation. The pain in strangulation ileus is not always localized in the position of the strangulated gut, but is referred to some other part of the abdomen. In two recent cases of acute volvulus of the sigmoid colon under my own observation the pain was referred to the region of the left kidney, which corresponds to the origin of the nerves supplying the mesosigmoid. When peristalsis takes place, either in strangulated or obturated ileus, the pain becomes inter-

mittent or colicky in character. The cause of this pain of intestinal colic has not been satisfactorily explained. The most characteristic symptom, then, of strangulated ileus is the sudden, intense abdominal pain. If situated in the right iliac fossa, it may suggest appendicitis; in the gall-bladder area, gallstone colic; if in the region of the kidney, renal colic. In my two cases of acute volvulus of the sigmoid the pain alone could not have been differentiated from that due to a stone in the kidney. In one it was referred to the testicle. A patient, therefore, who complains of sudden abdominal pain of such intensity that he begs for relief should be examined most critically and the possibility of an acute lesion demanding early operative relief considered. In the pain from strangulated ileus the shock is more marked than that observed in those cases associated with appendicitis, gallstones or renal calculus. As a rule, the shock is not as severe as that seen in acute hemorrhagic pancreatitis.

In the two cases of acute volvulus above referred to the immediate and quite distinct shock following the pain was of great value in excluding renal calculus. The primary nausea and vomiting are undoubtedly reflex in character. These symptoms are not at all characteristic of obstruction, and may be present in any acute abdominal lesion.

If the patient complaining of severe abdominal pain, nausea and vomiting is examined, one will find some symptoms of shock—the pulse is rapid, the face pale, and the patient will state that he feels distinctly weak, as if he has been kicked in the abdomen, while the moment before the attack of pain he may have been in the best of health and strength. If the abdomen is now carefully examined, one does not find the localized tenderness and muscle spasm, early signs in appendicitis and cholecystitis, but a more general muscle rigidity without tenderness. Now and then the distended loop above the strangulation can be palpated (Von Wahl's sign). If this is situated in the pelvis, it is felt per vaginam or rectum. The palpation of the distended loop may be looked upon as the pathognomonic symptom of strangulation ileus, but it can be distinguished only in the early hours before general distention obliterates it. In the recent case of acute volvulus of the sigmoid seen six hours after the onset the only symptoms were pain in the region of the kidney, nausea and slight shock, which had been more marked in the first two hours. Although all the abdominal muscles were held rigid, the patient complained absolutely of no tenderness. The muscles on the left side were more rigid than on the right. Yet there was absolutely no tenderness over the sigmoid. After a very careful palpation I could make out, I thought, a distended loop.

The next sign in strangulation ileus is peristalsis, to which Schlange first called attention in 1895. There is no doubt as to the interpretation of this symptom if it can be demonstrated.

How often peristalsis can be made out in strangulation ileus is impossible to state. It has been present and recorded in a certain number of cases early in the attack. The older view that peristal-

sis did not take place when the gut was strangulated has therefore been refuted. I have observed it early in postoperative obstruction, when the small intestine was involved; I have seen it in intussusception of the ileo-cecal type; it was present in a few cases of strangulation by bands, which I had the good fortune to observe within the first 24 hours. It is always absent in the late cases of the strangulation type, that is, when the small intestines are distended and to a certain degree paralyzed. One, therefore, should not wait for peristalsis; not consider its absence as excluding obstruction.

In my own experience, which I have referred to in 1901 (*Transactions of the American Surgical Association,* Vol. XIX, p. 139), a leucocytosis is a very important aid in the early recognition of intestinal strangulation. I think my colleague, Dr. Harvey Cushing, was the first to call attention to this fact in Dr. Halsted's clinic in 1898. I mentioned this in a report on hernia (*Johns Hopkins Hospital Reports,* Vol. VII, p. 332). Since then all the surgeons connected with this clinic have made blood-counts in cases of suspected strangulation, primary or postoperative, and have confirmed the early experience. The case of acute volvulus which I have mentioned here a number of times has a leucocyte count of 34,000 three hours after the onset. I have to thank Dr. Shaw of St. Agnes Hospital for this early observation.

Complete constipation is always present, but if the patient has not had a stool for a day or two before the onset of the acute attack, the first enema may bring away fecal contents, but this gives no relief, and after this repeated enemata are ineffectual.

In strangulated ileus, to summarize, the patient complains of acute abdominal pain, sudden in onset, with no previous premonitory symptoms—the first attack, as a rule. Reflex nausea and vomiting and peritoneal shock rapidly follow. If it is some hours after a meal, the vomitus contains nothing but the normal contents of the stomach, or if shortly after a meal, partially-digested food. Now and then the sudden pain comes so quickly after a large meal or indiscretions in diet or liquid that the patient attributes his pain to this fact. The pain continues, and if the patient is seen early one will find symptoms of shock. An enema, whether effectual or not, gives no relief. If the patient has vomited, a stomach washing is negative. The abdominal muscles are held somewhat rigid; the rigidity is most marked in the region of pain. There is no abdominal tenderness. Examined carefully, Von Wahl's loop or peristalsis may be made out. The blood-count will show a leucocytosis. If one or all of the three latter symptoms are present, the diagnosis can be made. If the three latter symptoms are absent, such a patient should receive nothing by mouth; the only treatment should consist of high enemata. If these are ineffectual and the symptoms persist, surgical consultation is indicated. I believe a careful examination in the early hours will demonstrate the characteristic signs—the palpable loop, the peristalsis or the leucocytosis. This, with the initial symptoms and the continuing absence of feces or

gas per anum, are sufficient to indicate immediate operation. In postoperative cases surgeons do not delay, but at the present time, unfortunately, few patients are admitted to the surgical clinic in this early stage. The later symptoms are fecal vomiting, general abdominal distention, continuing absolute constipation, and the signs of autointoxication. Now the diagnosis is simple, but the chances of recovery, even though the operation be performed early in this stage, are few.

In obturation ileus the acute primary symptoms are frequently absent. There is often a previous history of constipation and abdominal colic. In carcinoma of the large intestine there may be a history of blood in the stool or intermittent diarrhea and constipation. In this group of obturation ileus I have been impressed with the history of recurrent attacks of intestinal obstruction, that is, absolute constipation, vomiting (not fecal) and distention, which have been relieved after a day or two by cathartics and enemata. This history of a successful non-operative relief often puts the physician off his guard, and operative interference is delayed. In one of my own cases there was a history of five such attacks, one lasting five days. In obturation from carcinoma of the large intestine the obstruction of the lumen may not be absolutely complete and some little fecal matter and gas may pass, appear in the enema, and if this symptom is interpreted as a sign of relief the necessary operation is often further delayed. When the obturation is in the small intestine peristalsis is a constant early symptom. If the obstruction is high in the small intestine, distention is slight or absent, and vomiting of a forced character early. In obturation the symptoms are more obscure than in strangulation ileus, but the constipation, even though there be no vomiting or peristalsis, should be regarded as suspicious. The following distention, even without vomiting, is still more suspicious. In obturation of the colon the distention may be extreme before vomiting takes place. This clinical picture, with the evidence of some gas and feces in the enema, should be enough to allow a diagnosis of an obstruction of the large intestine. Early vomiting, absolute constipation, sometimes without much pain and little or no distention, indicate an obturation of the small intestine high up. Peristalsis can usually be made out.

I have not mentioned movable dullness in the abdomen. It is practically absent in obturation ileus, and is a late sign in strangulated ileus.

From my own experience in postoperative obstruction and from the few cases that I have seen in the early hours of primary intestinal obstruction I believe that it is not difficult to make a diagnosis at a period in which operative intervention promises an excellent chance of recovery. If the practitioners will avoid giving cathartics indiscriminately, place such patients in bed, give them nothing by mouth, employ the stomach tube and rectal enemata early, make a careful abdominal examination and blood-count, avoid morphia if possible (if the intense agony demands some relief before a decision as to operative intervention can be made, give small doses),

I feel quite confident that they will be able to recognize intestinal obstruction in the early hours. This has been accomplished in appendicitis, in perforated gastric and duodenal ulcer, why not in intestinal obstruction?

The problems in the surgery of intestinal obstruction present increasing difficulties with the duration of the attack and the possible complications. In strangulation ileus peritonitis may take place without gangrene or perforation. Autointoxication must be considered in all late cases.

Before operation the stomach should be washed out. Chloroform may be the best anesthetic. The anesthesia must be very carefully given. The washing out of the stomach does not always prevent vomiting under narcosis, and in such cases chloroform is better than ether. The selection of the position of the incision varies. If the exact position of the obstruction cannot be fixed, median laparotomy should be performed. In desperate cases a simple enterestomy under cocaine may have to be done. This is only feasible in obstruction of the large intestine or low down in the ileum. If possible the obstruction should be found and relieved. If the intestine above the point of obstruction is distended and filled with fluid contents, it should be evacuated, and if the symptoms have been present over 48 hours, enterostomy should be performed in addition to the relief of the obstruction. The mortality of operation after 48 hours without enterostomy is so definitely higher than with enterostomy that there appears at this time no question as to the efficacy of this additional safeguard. The object of the enterostomy is to aid the patient in immediately disposing of intestinal contents and combating autointoxication. When the intestine is the seat of gangrene the gangrenous loop must be taken out of the abdominal cavity. The surgeon has to decide between fixing the loop outside of the wound with enterostomy above, with later resection; resection at once, with fixation of the ends in the wound, or resection and suture. This decision is reached in individual cases. When there is obturation from a new growth, one must decide between enterostomy or colostomy alone, with a later operation for resection, and immediate resection. The earlier the operation takes place after the initial symptoms the easier to settle these questions, and the more frequently can the lesion of the intestine be relieved completely at one operation with the least mortality.

MINUTES OF PRINCE GEORGE COUNTY MEDICAL SOCIETY.

College Park, Md., January 12, 1907.

The Society met at 1 P. M. at the home of Dr. Eversfield. Called to order at 1.30 by the President, Dr. Fox, with 12 members (Drs. Fox, Eversfield, Etienne, McMillan, Taylor, Nally, Birdsall, Latimer, Perry, Willits, Griffith and McDonnell) present, also Dr. S. S. Buckley.

The name of Dr. C. S. Bradfield was presented for membership. Under the rules the application will be considered at the next meeting.

The following was presented by Dr. Latimer:

"WHEREAS, there exists in nearly every community a certain small class of individuals who habitually disregard any and all sense of obligation to reimburse any physician for services rendered;

"Resolved, That the members of this Society in the future shall not attend, professionally, any person or persons who reside in their respective communities who shall not have paid their indebtedness to their last medical attendant for any services rendered after this date if such last attendant be a member of this Society or a subscriber to this resolution. This not to apply to emergency calls demanded in the nature of humanity. And, with the purpose of making this resolution effective, we each exercise every reasonable diligence to ascertain such delinquent debtors."

After considerable discussion the resolution was carried by a two-thirds majority of the members present.

(A recess was here taken for dinner.)

It was moved and carried that every physician in the county and the insurance companies be notified of the action of the Society in opposition of the reduction in fees for regular life insurance examinations and in voting to refuse to make such examinations for a fee less than $5.

Dr. Latimer presented the report of the special committee, which was adopted, as follows:

"WHEREAS, some of the firms of manufacturing pharmacists are placing directions for administration on their bottles to encourage the laity to prescribe for themselves and thereby injure the patient and make the labors of the physician more difficult, be it

"Resolved, That the members of this Society, so far as possible, prescribe no products of firms following such practices.

"Be it further resolved, That the attention of the various State branches of the American Medical Association be called to this action."

The Society accepted Dr. Perry's invitation to meet at his house on March 9 at 1 o'clock, and also Dr. McDonnell's invitation to meet at his house at College Park on May 11.

A rising vote of thanks was then tendered to Dr. and Mrs. Eversfield for their hospitality.

Adjourned at 4 P. M. H. B. MCDONNELL, *Secretary.*

The resolution above referred to is as follows:

"WHEREAS, certain life insurance companies doing business in our county have reduced the medical examiner's fee from $5 to $3 by placing the fees on a sliding scale, all cases of $3000 or under being allowed $3, and as nine-tenths of our cases come under $3000, this practically cuts the fees for our work down two-thirds; and

"WHEREAS, in our opinion, $5 is the smallest amount for which the work can be properly done; now, therefore, be it

"Resolved by the Prince George County Medical Society, That every applicant for insurance in the old line insurance companies be charged $5, and no less; and be it further

"Resolved, That we, as a Society, pledge ourselves to these resolutions, and also to use our influence with all physicians of this county to carry out these resolutions, whether they are members of this Society or not."

Society Reports.

THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY.

MEETING HELD NOVEMBER 19, 1906—DR. BARKER IN THE CHAIR.

Cysts of the Breast—Dr. Bloodgood. Cysts of the breast vary from the most benign to the most malignant, and a diagnosis can be made in most instances only at an exploratory incision. Therefore one must be familiar with the differing cysts, the contents, inner wall and the tissue of the surrounding breast.

We have the galactocele in young lactating women, the cysts occurring at or before menopause, those with senile parenchymatous hypertrophy, those formed about papillomata, and malignant cysts.

Galactocele—Cysts occurring in the lactating breast may contain purulent material. They are of some months' duration. It is only necessary to remove the cyst. Carcinoma in the wall is rare.

Cysts occurring at the menopause, which varies in different women, are white in color as a rule, but may be hemorrhagic. It is justifiable to remove the cyst alone.

Simple Cysts—They have been observed in all ages, 30 to 70, and a few in senile breasts. Their walls are smooth, almost like the peritoneum, and they contain clear fluid. In the further development they may be multiple and of the same character. They are usually bilateral, and in 75 per cent. of the cases both breasts must be removed. In multiple cysts the tendency to carcinoma is slight. Small cysts are always lined by epitheleum, which they lose when the cysts become larger. This is a probable explanation of why we so seldom get carcinoma in the larger cysts; *i. e.*, in those over one centimeter in diameter. Small cysts filled with cellular detritus instead of fluid are in 50 per cent. of the cases cancer. Both breasts are to be removed, as the condition is often malignant.

There are two stages in the histology of senile parenchymatous hypertrophy: (1) The adenomatous stage. Here the cells lining the ducts are of a slightly higher type. (2) The acini of the ducts become dilated, probably due to a desquamation of the epithelial cells. This is the stage of ectasia. These dilations may become further dilated, and the lining then is no longer of epithelial cells, but of connective tissue, and is smooth. There may be hemorrhage into the wall, but never into the cyst. In other cases, instead of the cells desquamating and dilating the spaces into cysts, the epithelium of the walls is as marked as in the adeno-cystic stage. The entire breast may be filled with minute cysts. Cancer is common here.

Papillomatous Cysts—The papilloma is usually large; in one case it filled the entire cyst, but this is uncommon. Hemorrhage is quite common. The characteristic sign of cystic papilloma is hemorrhage from the nipple. There may, however, be no hemorrhage, for the duct may be occluded.

The presence of blood in a smooth-walled cyst is a diagnosis of cancer.

Fat in a lymph gland, it is interesting to note, may be mistaken for carcinoma metastasis, for the fat becomes infiltrated with connective tissue. The picture on fresh section may be very typical.

Cysts in Perithelial Angio-sarcomata—Recently Dr. Pancoast had a case of a woman with a rapid growth in the breast. On incision a cyst was found containing clear fluid. The wall was soft, rough and irregular, and it proved to be a perithelial angio-sarcoma, which is very rare. The zone of the tumor was sharply defined from the surrounding fat. Cysts are not uncommon in perithelial angio-sarcomata.

Sebaceous Cysts—They are near the surface and contain sebaceous or dermoid material. They may be malignant.

Dermoid cysts may be malignant also. Dr. Bloodgood mentioned a case in which cancer was not found in parts of the wall of the cyst, but on further section was seen with an infiltration of the skin and easily recognized.

The interesting points which we should bear in mind are: Cysts in young women in lactating breasts may be carcinomatous. After 30 we can determine from the wall of the cyst, the contents and the surrounding tissue whether or not to remove the cyst alone or the entire breast. One of the greatest aids for the diagnosis of malignancy is blood without papilloma or broken-down cheesy material.

A number of pictures were shown on the screen illustrating the various types of cysts.

Typhoid Spine—Dr. MacRae. The term "typhoid spine" was introduced by Dr. Gibney of New York in 1889 to designate a certain group of cases, the chief points concerning which are as follows: The condition generally comes on in convalescence not later than three months. Pain is the most marked feature. There is a distinct tendency to recover. Certain sensory symptoms are present.

Gibney considered it an inflammation of the soft parts holding the vertebra together. Concerning the actual condition, however, there was a difference of opinion, chiefly between two factions.

Gibney declared it to be a definite organic condition, while, on the other hand, there were those who believed it to be entirely a functional disorder without any organic change. The first view was somewhat at a disadvantage, since the condition was never fatal, there were no autopsy findings to confirm their belief, while in favor of the second view there were several points: First, the condition was only one of symptoms; secondly, the patients always got well; suppuration never occurred. This last was one of the strongest arguments against it being an organic change caused by the typhoid organisms, for, as is generally known, typhoid lesions nearly always suppurate.

Later, however, more men becoming interested in the subject, interesting reports of certain changes were made, such as kyphosis, lateral curvature, and signs of local inflammation (there was in no case, however, any report of suppuration), changes in the lower extremeties, such as wasting, changes in the reflexes and sensation, all of which are suggestive of organic changes.

It has been only recently, however, that the organic change has been really recognized. Two cases that we have had here had important changes worthy of note. The first case had had typhoid fever about three months before. The condition began with a sudden pain in the back, and in a short time he could hardly move. On his admission he could scarcely be touched, so that only an unsatisfactory examination could be made. Physically nothing was found, but the X-ray showed deposits of bone along the spine in the lumbar region. A few days after admission the patient had a relapse; he improved gradually, and three months later, when discharged, had a little limitation of the spine, and the X-ray showed an increase in the bony deposit. The second case showed very much the same condition on admission as did the other patient. On discharge two of the intervertebral discs and the lateral ligaments showed bony changes.

Clinically we have nowhere a condition the equal of the neurotic condition seen in typhoid spine. We have a patient getting along well in the typhoid stage, cheerful and feeling well; then in three or four days there is a complete transformation to a whining, complaining creature, crying for no particular reason except that he cannot help it. The pain, too, is helped very little by sedatives; morphia is only helpful in large doses, say a half a grain, which probably will have to be repeated. Certain local changes are seen also, such as redness and swelling. In the legs we have the changes in reflexes and sensation, with probable wasting. These may be due to an inflammatory extension; they all speak, however, for an organic change in the spine. There is without doubt in some cases a bony deposit, but we cannot say that in all cases we have an organic change.

Turning to spondylitis deformans we find a clinical picture similar to the typhoid spine, the same marked neurotic condition, the same tendency to get well, only more severe symptoms; in fact, a fairly exact parallel can be drawn between the two. In the arthritis deformans all conditions exist from that in which the whole spine is involved to that in which there is very little pain, so in typhoid we may have the different conditions from the severe to the mild.

Since arthritis is rare in typhoid it does not seem that all are arthritis, and since suppuration is so common in periostitis we cannot go further than Gibney, whose description was of a change in the ligaments, periostium, and perhaps in the disks.

From the findings of the spinal changes and the clinical conditions, as far as we can tell, we have here two parallel conditions. Since we believe the etiology of arthritis deformans to be an infection, we have here two other organisms that can cause it, namely, the typhoid and the paratyphoid bacilla. The influenza bacillus may be the cause also in some instances. Therefore, we may believe arthritis deformans to be due to many different organisms.

There is one point, though, that is not clear: Why is it that typhoid spine never suppurates? It is always dangerous to prophesy, but if this view is correct it is most probable that there will be sometime suppuration with the bone lesion.

To review briefly:

1. Bone changes have been demonstrated.

2. A comparison of typhoid spine with spondylitis deformans, conditions practically parallel.

3. Evidence favoring the view that arthritis deformans is due to some infectious agent.

In conclusion, it is suggested that the name typhoid spondylitis be substituted for the old name of typhoid spine, in spite of the fact that it is so firmly fixed.

A Case of Congenital Cystic Kidney—Dr. Gorter. Clinical Features—On October 23, 1905, Dr. Cole showed the patient before the Medical Society and gave his history, which, in brief, is as follows: A man, age 41, with a complaint of shortness of breath and a weakness in the lumbar region; the date of the onset is not known; he had had albumen in his urine for eight years. Two years ago his color changed; he became cyanotic, also pigmented over the cheek. These were signs of cardiac weakness.

The abdomen had become enlarged, but there was no discomfort; there was more or less ascites; as the ascites decreased a mass could be felt in the left flank. There were also prominences on the right side of a tumor-like mass extending down into the pelvis; these masses could be lifted forward. There were definite symptoms of cystic kidney—polyuria, low specific gravity, and, as a late symptom, bloody urine, also albumen and casts in the urine. The hematuri, Dr. Cole thought, was due to a rupture of small vessels in the cyst walls. Over the forehead and cheek there was pigment. Diagnosis—Cardiac weakness, hematuria, chronic nephritis and tumor.

In June, 1906, he first came under the observation of Dr. Gorter. The complaint then was indigestion and general lassitude. The abdominal examination was the same as above, the urine was alkaline and contained hyaline casts. On July 12, 1906, his temperature was 103° and the pulse rapid and weak; there was dyspnoea and precordial pain. The lung bases had filled up. Under an infusion of digitalis, ammonium carbonate and ——— the lungs cleared up, except for a definite area of consolidation. A pericardial friction rub developed, which gradually decreased as the cardiac dullness increased. The temperature varied between 100° and 103°. Uraemia developed later with delirium and coma, and death followed from odema of the lungs.

Autopsy Report—Dr. Whipple. Anitomical Diagnosis—Congenital cystic kidney, extreme arterial sclerosis, organizing pericarditis, broncho-pneumonia, congestion and odema of the dependent parts of the lung, cardiac hypertrophy and dilitation with diffuse fibrous myocarditis, general pigmentation of the skin, marked flattening of the adrenals.

The kidneys filled both flanks, completely forcing the intestines into a small gutter, as it were, between them; together they weighed 5200 grams. They were made up of bunches of cysts of all sizes; many contained fluid.

some colloid material, others old blood clots. The pelves were fan-shaped, the ureters normal. The adrenals were flattened between the upper poles of the kidney and the diaphram. Dr. Cole's theory of the pigmentation was that it was due to compression of the adrenals, but the microscopic examination showed nothing to account for it. There was fatty degeneration of the cortex, but the medulla was normal. It was possible that the pigmentation was due to the same cause as that of the pigmentation in abdominal anuerysm or any large abdominal tumor. The liver, weighing 2900 grams, was also cystic; the cysts, as a rule, had smooth linings; some contained fluid, some a colloid material.

Sections of the liver, kidney and pancreas were shown under the microscope.

In the pancreas there were many cysts formed from the duct and lined by cuboidal epithelium.

In the kidneys many of the glomerula had thickened capsules; there was also a thickening of the tissue between the tubes, many of which contained blood casts and fresh blood. There were none of the malformations so often met with in such cases.

Dr. Whipple also reported another case of congenital cystic kidney in a female child from the obstetrical ward, who lived but 45 days. The anatomical diagnosis: Double-cleft palate, anemia and emaciation, double uterus, double ureters and pelves of kidney; the ovaries and tubes normal. To the naked eye the kidneys were normal, but under the microscope they were seen to be full of small cysts from dilated tubules; some of the glomerular capsules were dilated more or less, and some of the capsules had ruptured into neighboring ones; some of the glomerula were of a rudimentary type, as in congenital syphilis. This is a point in favor of the idea that the cysts are due to a congenital defect rather than a cystic development. The tubules showed casts; the stroma was slightly increased in the boundary zone, but on careful examination it was seen to be secondary to the cyst formation, and therefore had nothing to do with the formation of the cysts. The increase in glomerular capsules and in the cortex was primary. Part of the parenchymatous functions of the kidneys must have been active, for the child lived 45 days.

Common Theories of Cystic Kidney.—Virchow's—Due to a papilitis and a constricting of the collecting tubles with formation of retention cysts.

Cornell's—Retention due to diffuse foetal nephritis. There are no cases to support this theory.

Von Kohlman's—A true neoplasm of the adenomatous type.

Hilderbrand's—A malformation; a failure of the glomerular cuffs and the tubules to unite. This is not upheld by the sections, for the most marked dilatation is often in the collecting tubules.

A later theory was that it was a malformation with a proliferation. Malformation is favored by the fact that the kidneys are bilaterally affected and occur in connections with other malformations.

Book Reviews.

Woman—In Girlhood, Wifehood, Motherhood. Her Responsibilities and Her Duties at All Periods of Life. A Guide in the Maintenance of Her Own Health and that of Her Children. By Myer Solis-Cohen, A.B., M.D., Instructor in Physical Diagnosis, University of Pennsylvania, etc. Profusely illustrated with color plates, scientific drawings and halftone engravings. Philadelphia, Chicago and Toronto: The John C. Winston Company. 1906.

Physicians can very heartily recommend this book to patients who need a handy guide in the physiology and hygiene of womanhood. The first part of the book includes seven chapters on health and beauty, one chapter being devoted to bathing, one to the care of the teeth, nails and hair, one to the figure and carriage, one to clothing from the hygienic and artistic standpoints, one to food and drink, and one to work, rest and recreation. The second part of the book concerns the anatomy and physiology of sex, puberty, menstruation, courtship and marriage, heredity, pregnancy, and the menopause.

The third part of the book treats of the preparations for confinement, the physiology of childbirth, the management of labor, and the care of the mother after labor.

Part IV is devoted to the care of the infant. There are two good chapters on feeding, one on bathing, one on clothing, three chapters on sleep, exercise, and mental and moral training, and two chapters on the care of sick infants.

Part V concerns the causes, prevention, and cure of diseases peculiar to women.

There is a complete and satisfactory index and a glossary.

Golden Rules of Surgery. Aphorisms, Observations, and Reflections on the Science and Art of Surgery. Being a Guide for Surgeons and Those Who Would Become Surgeons. By Augustus Charles Bernays, A.M., M.D., M.R.C.S. Eng. St. Louis: The C. V. Mosby Medical Book Co. 1906.

Golden Rules of Pediatrics. Aphorisms, Observations, and Precepts on the Science and Art of Pediatrics, giving Practical Rules for Diagnosis and Prognosis, the Essentials of Infant Feeding, and the Principles of Scientific Treatment. By John Zahorsky, A.B., M.D., Clinical Professor of Pediatrics in Washington University Medical Department, etc., with an Introduction by E. W. Saunders, M.D., Professor of Diseases of Children and Clinical Midwifery, Washington University, etc. St. Louis: The C. V. Mosby Medical Book Co. 1906.

These two books belong to a new "Medical Guides and Monograph Series." The "Essentials" and "Compends" might now retire in favor of their handsomer though unacknowledged offspring, the "Golden Rules." Almost any reason would be good enough for the retirement of "Essentials" and "Compends." Their passing will cause some regret among medical

licensing boards, for these little manuals supply examiners with destructive erudition in tabloid form such as the merciful business of examining seems to require. There is no telling what examiners will do if the "Compends" perish. If they fall back on the next best, but somewhat inferior, substitute, it will necessarily be a kind of intellectual chewing-gum which no publisher has yet invented. If the examiners in their extremity move forward, here are the Golden Rules, which are more nutritious and might sustain very light feeders. There are calories in Golden Rules, but it would be most difficult to make a balanced ration out of Remembers, Bewares, Nevers, and Be sures. The Golden Rules are good enough, their number being considered, and there are plenty of them, such as they are. Bernays is always interesting, and Zahorsky authoritative. They can make as good cachous as anyone else, but there is a certain danger in these little confections. Students and examiners become addicted to them. It is decidedly a morbid addiction, like eating slatepencils or biting the nails. There will be other Golden Rules, so the publishers say—for instance, a $3 package on diagnosis and treatment. The publishers are the agents, and authors merely accessories, to this mischief. The worst of it is that the rules will be good—as good as beans—and as liable to sprout under suitable conditions of warmth and moisture. But for immediate ingestion these Golden Rules remind me irresistibly of the plaintive wail of the Irish lass:

"Give me three grains of corn, mother; give me three grains of corn.
'Twill keep the little life I have till the coming of the morn."

BOOKS RECEIVED.

Receipt is acknowledged of the following books:

Pocket Formulary. By E. Q. Thornton, M.D. Eighth edition, revised. Publishers, Lea Bros. & Co. Price, $1.50 net.

Manual of Clinical Chemistry. By A. E. Austin, A.B., M.D. Publishers, D. C. Heath & Co. 1907.

A Manual of Prescription Writing. By Matthew D. Mann, A.M., M.D. Revised by Ed Coc Mann, M.D. Sixth edition, revised, enlarged and corrected according to the U. S. Pharmacopeia of 1906. New York and London: G. P. Putnam's Sons. 1907.

The New Hygiene. By Elie Matchnikoff. Publishers, W. T. Keener & Co. 1906. $1.

Diseases of the Nose and Throat.. By J. Bruce Ferguson, M.D. Publishers, Lea Bros. & Co. $1.

A Textbook of the Practice of Medicine. By Hobart Amory Hare, M.D., B.Sc. Second edition, revised and enlarged. Publishers, Lea Bros. & Co. 1907. Cloth, $5 net.

Success in Life. By Emil Reich. Publishers, Duffield & Co. 1907.

Heaven and Hell. By Emanuel Swedenborg. Publisher, Swedenborg Printing Bureau. 10 cents.

Annual Report of the Bureau of Health for the Philippine Islands. By Victor G. Heiser. July 1, 1905, to June 30, 1906. Manila Bureau of Printing. 1906.

Wilshire Editorials. By Gaylord Wilshire. Publisher, Wilshire Book Co. $1.

MARYLAND MEDICAL JOURNAL.

JOHN S. FULTON, M.D., *Editor.*

Associate Editors:

THOMAS R. BROWN, M.D. | HUGH H. YOUNG, M.D.
ROBERT REULING, M.D. | JOSE L. HIRSH, M.D.

BALTIMORE, APRIL, 1907

AN AWAKENING OF THE PROFESSIONAL CONSCIENCE.

AT the public meeting recently held by the Medical and Chirurgical Faculty in McCoy Hall a movement was started which should not suffer an instant's pause until medical men have fully realized, and lay people fully recognized, the relations of medicine to the public welfare. Groups of medical men have now and then persuaded lay people to come out in numbers and discuss public questions, and much good has resulted from such conferences. But a lay audience has never before assembled in Maryland to hear the medical profession itself discussed, nor have Maryland physicians ever before been subjected in public to such incisive commentary as that of Dr. McCormack. If the text of Dr. McCormack's remarks had been printed and circulated among physicians in advance of the meeting, it is probable that a strong effort would have been made to prevent his public address in McCoy Hall. But no secret would have been preserved by restraining Dr. McCormack. Everybody knows that in civic virtue we doctors are very feeble folk, and everybody knows the sources of our weakness. Dr. McCormack simply helped us over that difficult point of open confession which is good for the soul. The sins that so easily beset us can never be cured until we are sufficiently humiliated by them. Of all the kinds of special knowledge which bear on important public questions medical knowledge is the least influential, and this fact, notorious as it is, should humiliate us sufficiently. But this unpleasant notoriety has not humiliated us sufficiently. We require and will doubtless receive publicity more specific, such as Mr. Bok and Dr. McCormack have prepared for us. Whatever discipline we need, our masters, the lay public, will give us, and the sooner the better for us and for the public. Medical knowledge is not power. Medical knowledge is inert in proportion to the inertia of medical men. On all public questions this inertia exceeds the inertia of all other public vocations; it is a monumental, massive inertia. If medical knowledge is not powerful for public good, how can it possibly be, in honest measure, powerful for private good? Who is going to touch us on the raw through this absurd pretense? Someone, surely, will count up the hundreds of medical men who do not care for laboratory examinations of blood, or of sputum, or of exudates, or of urine, or of drinking water or milk; who do not belong to medical societies, or, being affiliated, care for medical organization only as a means of advancing their material interests.

Someone will discover the existence of schools where medical knowledge, such as they have, is held as a marketable commodity, to be sold in measured amounts and in graded qualities to uninformed and indiscriminating buyers.

Someone, not of the profession, will trace these things to their roots, and will tell us where, as we already know, they are—in the selfishness and envy which grow so freely in the secluded fields of private practice.

There is no doubt about Dr. McCormack's pre-eminent qualification to be our mentor, and there is every reason for us to heed his admonitions before some unfriendly herald searches out and proclaims our iniquities. The experience which has given Dr. McCormack his unusual qualifications is in itself most significant. A few years ago he was chosen by the trustees of the American Medical Association to carry into all the States a well-considered plan of medical organization. To a superficial observer it might appear that Dr. McCormack's mission has been remarkably successful, for the American Medical Association has grown numerically much stronger and its plan of local organization has been adopted in nearly every State. But Dr. McCormack has discovered for himself another mission and a more important one than that originally entrusted to him. He knows that the organization which he is supposed to have constructed is hollow, hollow, hollow, a non-vital, non-viable structure. He has been trying to organize antipathies, and that is impossible. You can stand them in a row, they can be frightened or driven into rank and file and put through a few simple paces, but antipathies cannot be united to any common purpose, not even to an evil purpose. Sordid sympathies are but a little better animated than antipathies. No sort of organization can grow except it is warmed by clean and virile sympathies, and these, it appears, do not abound among medical men.

With this unpleasant truth impressed upon him, and confirmed and reconfirmed by repeated observations on the body medical, Dr. McCormack became a far more useful man than he could ever have been as an agent of professional organization. The enemy of medical organization is a scurvy of the soul which attacks men who confine their walks too closely to the narrow paths of medical practice. But this scurvy is no more inimical to medical fellowship than medical fellowship to this scurvy. Every man who cuts himself off, or permits himself to be cut off, from the fellowship of his calling may be attacked by this malady. The best general prophylaxis is the assembling of ourselves together, and if this be done for fellowship's sake only it is quite as effective, and in the long run as profitable, as to meet under the forms of scientific organization. To be well nourished is to be immune to this deadly disorder. In these days, surely, the good things of medicine are enough to go round and rich enough to bear the cost of active distribution. Who is, in truth, more selfish, he who in his loneliness has been overtaken and made unlovely by an insidious soul starvation, or he who, having this world's good and seeing his brother have need, shutteth up his compassion?

The medical profession must become more aggressive in its fellowship. If a man will not go to the society, the society should go to the man. A man may ask: "What can I get out of the society?" Men do ask that question. It indicates in general that a man is getting very little out of life, and that life is getting less than he owes out of him. But such a man may not be far gone in anything worse than intellectual anorexia, and a square meal may set him right again. For many men, ours is the loneliest of all vocations, and the most subject to certain kinds of moral atrophy. It would

be real rescue work if well-nourished men would hunt in tens or scores for here and there a fellow who has lived with himself long enough to have lost his own favor. You cannot tempt a man like that with a program, or a speaker from the city. You and I do not follow such lures. We go to medical societies, really and truly, to sit by some fellow—any fellow—several fellows—and, between the acts, have a care-free run in the open. The society spirit is the social spirit, and even in a scientific society the most useful member is he who can kick his technical togs into the corner with the least ceremony. The society spirit ought to carry the society to the unsocial man, if the society is in fact a highly-animated body.

THE VENEREAL PERIL.

It was good to hear Dr. McCormack's remarks about the venereal diseases. He launched into this subject without warning or apology, sweeping past the conventional barriers without shock and without surprise. Of the many persons present, some probably would not have come if they had known that this subject would be discussed, but no one, it is safe to say, wished himself absent. Every possible doubt as to the propriety of Dr. McCormack's remarks must have been removed by the Rev. Dr. Hussey, who spoke later, and devoted the principal part of his address to this topic. Dr. Hussey evidently did not expect any such opportunity as Dr. McCormack provided, and it was also clear that the opening seemed to Dr. Hussey as important as it was unexpected. Among the neglected phases of public hygiene none has more urgent claims upon the professional conscience than this of the venereal diseases. This is the most refractory problem in State medicine. Except that a vast amount of remediable misery is hidden by our studious evasion, we know practically nothing about this problem. Because the communicative mode is, as a rule, wilful, we have chosen to compound the destructiveness of these diseases by wilfully ignoring them. There never was a unanimity more villainous than this. No hopeful suggestion concerning the prevention of the venereal diseases has ever been offered and none may be expected while this vicious unanimity remains unbroken. We have imagined that the barriers of wilful ignorance which surround this problem are extremely difficult to pass. It is not so. The meeting at McCoy Hall proved that it is easier to ignore the barriers than it has been, for so many long years, to ignore the problem. For those whose consciences have been burdened by this incubus the era of despondency has passed. When we can discuss the question there is a chance of its solution. The signs of the times are hopeful. The *Ladies' Home Journal* announced some months ago, and is now carrying out, its purpose to combat this evil according to its urgency and without artifice. The Society of Sanitary and Moral Prophylaxis, organized about three years ago under the leadership of Dr. Prince A. Morrow, has grown steadily in influence.

The venereal peril is now in the arena and may be examined as it has never been examined before. For the present it is enough to say that the subject must be studied. No one knows what we shall do about it, but we shall certainly not restore the fabric of false modesty and sham blindness, which for centuries has provided a seclusion most favorable to the growth of a deadly evil.

Medical Items.

Mrs. Osler, the mother of Dr. William Osler, died in Toronto on March 18 at the age of 100 years and 3 months.

Dr. W. W. Keen retired from the service of Jefferson Medical College, Philadelphia, on March 11, and will sail for Europe on March 27 to be absent for two years.

The residence of Dr. J. T. Rothrock on South Mountain, near the Mountainside Sanitarium for Tuberculosis, was burned on March 10. The loss is estimated at $10,000.

The Commissioner of Health of Pennsylvania is asking appropriations to the amount of $2,100,000 for the coming year, and the prospect of getting something like this amount is very good.

Prof. Friedrich Muller of Munich visited Baltimore on March 20. On March 21 he addressed the Johns Hopkins Medical Society and on March 23 the Baltimore City Medical Society.

The Michigan State Sanatorium for Tuberculosis will be opened for patients about April 1. This sanatorium is situated at Howell and has accommodations for about 100 patients.

Delaware has a new medical-practice act, replacing that of 1895. The bill passed the House without difficulty. The Christian Scientists opposed it most vigorously in the Senate, but without success.

Congress adjourned on March 4 without having passed the bill for registration of tuberculosis. The condition of the bill was, however, quite favorable. The committees of both Houses were in favor of the bill.

The study of bubonic plague has led to another sacrifice of life. In the laboratory of the fortress of Cronstadt, near St. Petersburg, where a number of scientific men have been doing experimental work on plague, Dr. Schreiber was accidentlly inoculated and died.

The Philadelphia County Medical Society has taken a hand in the movement to ameliorate the practice of matrimony. On March 14 a resolution was passed urging the Legislature to pass a bill requiring persons who propose to marry to file certificates stating that both parties are, in the opinion of a qualified physician, free from disease transmissible to progeny.

A bill appropriating $600,000 has been introduced in the Pennsylvania Legislature for the purpose of establishing and maintaining one or more sanatoria for the care of indigent consumptives under the supervision of the State Department of Health. If this bill passes, the appropriations to the State Department of Health will exceed $2,500,000.

The program of the fourth annual meeting of the Philippine Islands Medical Association has reached us. This meeting was held on February 27, 28 and March 1, 2 in the House of Delegates at Manila. Among the members are three Baltimoreans—Dr. Harry T. Marshall, Dr. Henry Page, and Dr. Arlington Pond. Dr. Marshall read a paper on March 2 entitled "The Recent Trend of Immunity Research."

The date of the International Congress on Tuberculosis has been tentatively fixed. It will be held in Washington in the last week of September and first week of October, 1908. The National Association for the Study and Prevention of Tuberculosis will be responsible for the work of organization. A special committee on the congress has been formed and a secretary-general has been selected. The headquarters for organization will be in Washington.

A surgeon in Germany has an interesting controversy with a man on whom he operated for stone. The surgeon wants his fee and the patient wants his stone. The surgeon will not give up the stone and the patient will not give up the money. The surgeon wants the stone because its nucleus is a catheter tip. The patient wants the stone because it is his. He does not have to say why he looks upon the stone as a thing of value. It is said that the case will go to the courts.

The Rush Hospital for Consumptives in Philadelphia is still in trouble. Residents of the neighborhood have protested against the hospital from the very incipiency of the project. The building is yet unfinished, and the trustees have asked the Legislature for $140,000 to complete it. The opposition asks the Legislature to deny this appropriation on the ground that the soft-coal smoke renders the air of that vicinity prejudicial to those having lung diseases, that the hospital is a nuisance, and that its further extension will further depreciate the adjacent property, which is already materially damaged by the proximity of the hospital.

The Liverpool School of Tropical Medicine has undertaken to raise a fund for the creation and maintenance of a research professorship in tropical medicine in memory of Dr. Joseph

Everett Dutton. Dr. Dutton died at Kasongo, Central Africa, while investigating the "tick fever." He contracted the disease in the course of his studies. Dr. Dutton had served on four successive expeditions sent out by the Liverpool School of Tropical Medicine, and his researches not only brought him great distinction, but also extended the renown of his school.

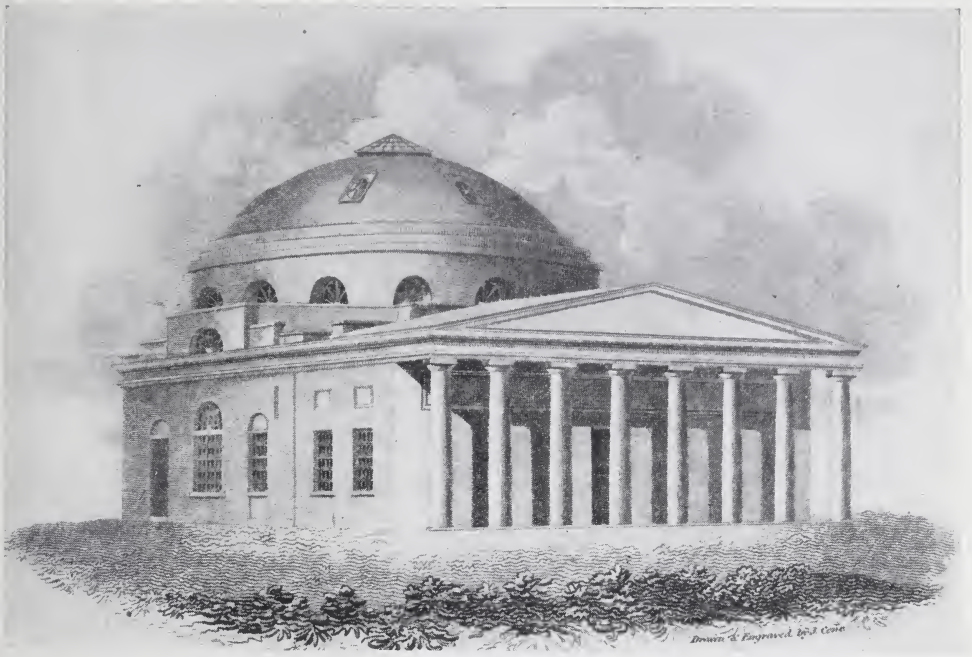
In the history of smallpox in 1907 the most appropriate incident so far recorded happened in Missouri. A member of the Legislature was attacked by smallpox in so mild a form that he was able to attend to his duties, and did so, the nature of his disease being unknown. A panic resulted when his fellow-members learned that the innocent-looking eruption was that of smallpox. Several other members were attacked. Give us the particulars minutely. An unvaccinated Legislature and its smallpox history ought to be Exhibit A for the next 10 years.

The Maryland Association for the Prevention and Relief of Tuberculosis has made a successful appeal to the public for the sum of $10,000 to be applied to its needs for the coming year. The finance committee, under the chairmanship of Mr. B. Howell Griswold, started the work with a call to all the people to "Help Build the Fence." The fence symbolizes the work of prevention in which the Association is engaged. The required amount was raised within four weeks, and later contributions are to be devoted to the maintenance of a special tuberculosis nurse.

W. B. Saunders Company of Philadelphia and London have just issued a revision of their handsome illustrated catalogue of medical, surgical and scientific publications. Beyond question this is the most elaborate and useful catalogue we have ever seen, the descriptions of the books are so full, the specimen illustrations are so representative of the pictorial feature of the books from which they are taken, and the mechanical get-up so entirely in keeping with the high order of the context. The authors listed are all men of recognized eminence in every branch and specialty of medical science. The catalogue is well worth having, and we understand a copy will be sent free upon request.

Army Medical Corps Examinations.—Preliminary examinations for appointment of assistant surgeons in the army will be held on April 19 and July 29, 1907, at points to be hereafter designated. Permission to appear for examination can be obtained upon application to the Surgeon-General, United States Army, Washington, D. C., from whom full information concerning the examination can be procured. The essential requirements to securing an invitation are that the applicant shall be a citizen of the United States, shall be between 22 and 30 years of age, a graduate of a medical school legally authorized to confer the degree of doctor of medicine, shall be of good moral character and habits, and shall have had at least one year's hospital training or its equivalent in practice. The examinations will be held concurrently throughout the country at points where boards can be convened. Due consideration will be given to the localities from which applications are received in order to lessen the traveling expenses of applicants as much as possible. In order to perfect all necessary arrangements for the examinations of April 29, applications must be complete and in possession of the Surgeon-General on or before April 1. Early attention is therefore enjoined upon all intending applicants. There are at present 25 vacancies in the medical corps of the army.

At the last meeting of the Mississippi Valley Medical Association it was decided to offer a prize of $100 for the best essay on some medical or surgical subject. The competition is to be limited to those who, at the time of entering the competition as well as at the time of the award, shall be members in good standing of the Mississippi Valley Medical Association. The award will be made by a committee appointed for the purpose, consisting of Drs. Hugh T. Patrick of Chicago, A. H. Cordier of Kansas City and Chas. H. Hughes of St. Louis. The name of the author is to be enclosed in a sealed envelope bearing some motto or device, and the essay is to be marked by the same motto or device. The name of the successful author and the title of his essay will be announced at the next meeting of the Association, to be held in Columbus, Ohio, October 8, 9, 10, 1907, and the award will be made at that time. The successful essayist will be notified at least two weeks prior to the meeting, and he will be expected to read his essay at that meeting. The essay is to be published in the organ of the Association. All essays must be typewritten, and are to be sent to the secretary, Dr. Henry Enos Tuley, 111 West Kentucky street, Louisville, Ky., on or before August 1, 1907, after which date no essay will be received. The committee reserves the right to reject any or all essays.



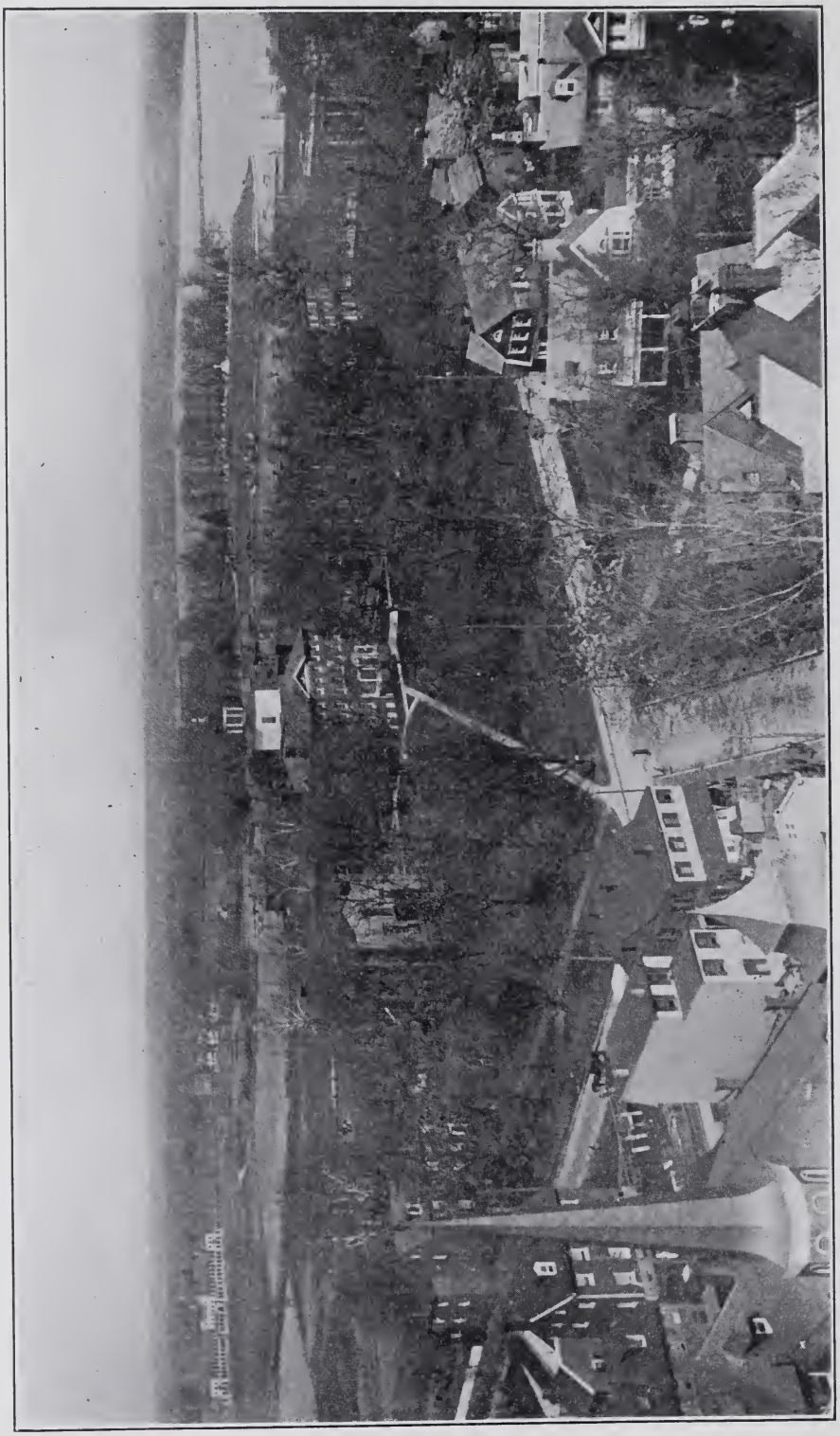
OLDEST OF THE TWO ORIGINAL UNIVERSITY PICTURES.

THE BUILDING, MODELED AFTER THE PANTHEON AT ROME, WAS AT THE TIME OF ITS CONSTRUCTION, 1812, CONSIDERED THE MOST IMPOSING MEDICAL BUILDING IN AMERICA. ACKNOWLEDGMENT IS MADE TO THE LEWIS PUBLISHING CO. OF NEW YORK FOR THE LOAN OF THIS CUT, WHICH WILL APPEAR IN THE FORTHCOMING "HISTORY OF THE UNIVERSITY OF MARYLAND" BY DR. CORDELL.

THE CENTENNIAL CELEBRATION OF THE UNIVERSITY OF MARYLAND.

IN the life history of institutions in this youthful country of ours 100 years is a long period, and there are but few seminaries of learning that have attained this comparatively hoary age. These thoughts are suggested by the approaching celebration of the 100th anniversary of the founding of the University of Maryland, an event that is of much more than local interest. One hundred years ago Baltimore was a city of about 40,000 inhabitants, and was increasing rapidly in population and importance. Previous to this time the facilities for acquiring a medical education were very meager and consisted principally in a term of apprenticeship to a practicing physician, and subsequently, perhaps, attendance on medical lectures at Philadelphia or Edinburgh.

An effort had been made to establish a medical college in 1801 and 1802, but it was not until December 18, 1807, that the Legislature passed an act for the founding of the College of Medicine of Maryland. The first members of the Faculty were John B. Davidge, M.D., and James Cocke, M.D., joint professors of anatomy, surgery and physiology; George Brown, M.D., professor of the practice and theory of medicine; John Shaw, M.D., professor of Chemistry; Thos. E. Bond, M.D., professor of materia medica, and William Donaldson, M.D., professor of the institutes of medicine. The College of Medicine of Maryland was fifth in priority in the United States, the College of Medicine of Philadelphia having been established in 1765, Harvard Medical School in 1782, Dartmouth in 1798, and Kings College, New York, in 1807. The number of students in attendance at the College of Medicine of Maryland the first year, 1807-8, was 7; in 1808-9, 10, and in 1809-10, 18. Five were graduated in 1810 and 10 in 1811. The names of



THE HISTORIC ST. JOHN'S COLLEGE AND BUILDINGS AT ANNAPOLIS, NOW AFFILIATED WITH THE UNIVERSITY OF MARYLAND AS THE DEPARTMENT OF ARTS AND SCIENCES. THE COLLEGE BUILDINGS AND CAMPUS ARE PICTURESQUELY SHOWN IN THE CENTER OF THE FOREGROUND.

JOHN BEALE DAVIDGE, M.D.

FOUNDER OF THE COLLEGE OF MEDICINE OF MARYLAND (UNIVERSITY OF MARYLAND). FIRST DEAN. PROFESSOR OF ANATOMY AND SURGERY. INVENTOR OF THE "AMERICAN METHOD OF AMPUTATION." BORN AT ANNAPOLIS, 1768. DEGREE OF M.D. AT THE UNIVERSITY OF GLASGOW. PRACTICED FIRST AT BIRMINGHAM, ENGLAND; RETURNED TO BALTIMORE, 1796. DIED, 1829.

these graduates are not certainly known, but from 1812 to the present time the names of the graduates have been preserved, and there now hangs in the Faculty room of the Medical School the diploma of Corbin Amos of Harford county, Maryland, conferred on the 4th of May, 1812. On the 7th of May, 1812, the erection of a splendid college building, modelled after the Pantheon at Rome, was begun at the northeast corner of Greene and Lombard streets, and was, when completed, the most imposing medical building in America, and remains to this day a monument to the artistic skill of its distinguished architect, R. C. Long. Of the early professors of the College of Medicine John B. Davidge and Nathaniel Potter continued to fill their chairs with distinction for many years, and William Gibson, professor of surgery, after remaining in Baltimore until 1819, was called to the chair of surgery in the University of Pennsylvania, which he filled with great distinction for a period of 36 years.

In 1812 the Legislature of Maryland authorized the Medical College of Maryland to "annex to itself the other three colleges or faculties, viz., the Faculty of Divinity, the Faculty of Law and the Faculty of the Arts and Sciences, and that the four faculties or colleges thus united shall be and they are hereby constituted an University, by the name and under the title of The University of Maryland."

The Medical School of the University of Maryland has therefore the almost or quite unique distinction of having been the nucleus from which a university has sprung. It may have been that the ancient University of Salernum, which kept alive the almost extinct spark of learning in the middle ages, also had its origin in a medical school, but beyond these examples I know of no others.

The University of Maryland as thus constituted was not, however, the first institution of universal learning to have been chartered by the Legislature as the University of Maryland. In 1784 St. John's College at Annapolis and Washington College at Chestertown were authorized to form a union under the title of the University of Maryland, but for causes unknown to me, but not difficult to guess, this affiliation was never actually carried into effect.

With the passage of the act of 1812 the School of Medicine proceeded to constitute and annex the other faculties in accordance with its charter; but whilst the Legislature conferred ample powers and privileges upon the infant university, it made no provision for

LECTURE TICKETS USED IN THE FIRST PERIOD OF THE INSTITUTION BY PROFESSORS DAVIDGE, POTTER, DE BUTTS, BAKER AND GIBSON.

the financial support of its ward. The School of Divinity was never actually organized, though a professor of theology was elected, who preached some sermons to the medical students. The School of Law led a somewhat precarious existence until 1836, when it fell into a sleep until 1869. It then awoke with a bound, and under the leadership of Hon. John P. Poe, LL.D., and the able men associated with him, has been in active and successful effort to the present time, with a yearly enrollment of about 250 students. Most of the legal practitioners of Maryland, since the reorganization in 1869, have been students and graduates of this school, and most of the eminent jurists of the city and State have at some time been connected with the institution.

The Medical School has had a continuous existence since its establishment in 1807, and though there have been mutations in its affairs and periods of depression, it has continued to exercise the functions for which it was founded. Without adequate financial assistance it has always endeavored to stand well in the advance of medical progress and not to lag in the rear. In many ways it has been a pioneer in medical instruction, and was one of the first schools to place a high value upon clinical teaching and to establish its own hospital for this purpose. To this day it has remained a great clinical school.

The Dental Department was established in 1882, and has been an active and successful school, with from 175 to 200 students annually in attendance. In 1904 the Maryland College of Pharmacy, after a highly distinguished separate existence of more than 60 years, became the Department of Pharmacy of the University. Its classes contain about 85 students.

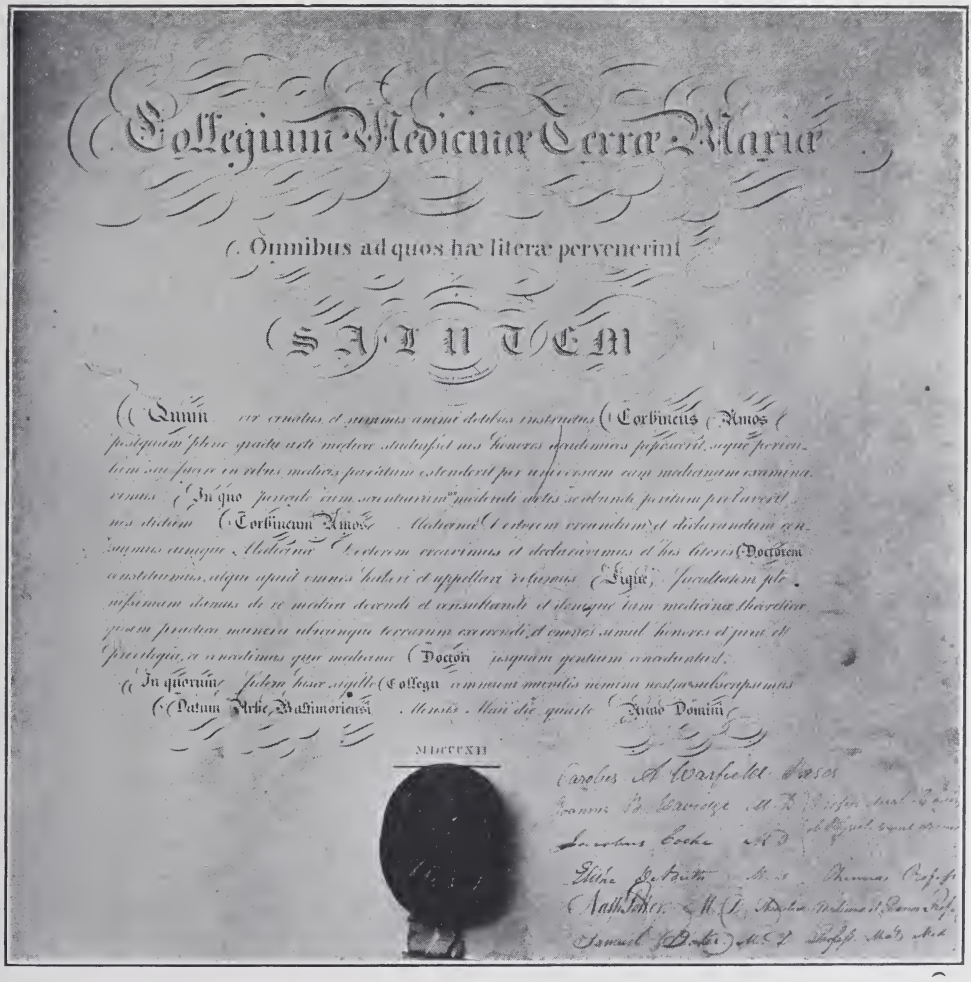
The School of Arts and Sciences was never well organized and led a precarious existence, and several years prior to the death of its principal, the Rev. E. A. Dalrymple, in 1881, it became defunct. It is with especial appropriateness that St. John's College, which was authorized to form an integral component of the first University of Maryland by the Legislature of 1784, and after a separate and useful career of 123 years, by agreement has become affiliated with the present University as the Department of the Arts and Sciences, and thus restores to the University its lost member. St. John's College

is the lineal descendant of King William's School, founded at Annapolis in 1696. Many of the most illustrious sons of Maryland have received their scholastic education at St. John's, and it is now in full vigor with over 200 students, good equipment, a fine campus and a group of interesting and well-appointed buildings.

Another essential and perhaps even more ornamental addendum to the University is the Training School for Nurses of the University Hospital, which was established in 1890, and has at this time about 60 pupils. The course of training is of three years' duration, and the graduates are eagerly sought for.

From the foregoing it will be seen that the University of Maryland has not only had a useful and honorable past, but is now the largest institution of learning in the State, with over 1100 pupils in attendance.

It is proposed to celebrate the centennial anniversary of the founding of the University from May 30 to June 2 inclusive, and it is greatly desired that there may be a very large attendance of former students and graduates, as well as invited guests from a distance. The invitations are being issued, but it will scarcely be possible to reach all the alumni, and some may think they have been slighted. All are invited. Come!



THE DIPLOMA OF CORBIN AMOS OF HARFORD COUNTY, MARYLAND; CONFERRED IN 1812 BY THE "COLLEGE OF MEDICINE OF MARYLAND" (UNIVERSITY OF MARYLAND).

THE UNIVERSITY AS A PIONEER INSTITUTION.

The first medical school in America to make dissecting a compulsory part of the curriculum.

The first to establish separate and independent chairs of diseases of women and children and of eye and ear diseases.

One of the very first to provide for adequate clinical instruction by the erection of its own hospital.

Among the first to teach hygiene and medical jurisprudence and to establish a medical library.

In the Medical Department were delivered the first dental lectures in this country.

SEAL OF THE UNIVERSITY.
REPRODUCED FROM A MOUNTED BAS RELIEF.

The lecturer was the first dental practitioner registered to practice his profession in the United States.

Together with his associate he organized the first dental college in the world.

Its School of Pharmacy was the pioneer in employing separate professors for all branches taught.

The Department of Pharmacy took the initiative in establishing laboratories for practical teaching and exercises.

IN connection with the forthcoming Centennial, the University will have an opportunity to show honor to a number of her alumni who have attained distinction in various walks of life. As the Institution has been devoted so largely to professional training, it is especially in the professions we find them prominent. There is hardly a city of the country in which there are not a number of eminent doctors, lawyers, ministers, pharmacists, dentists, teachers, etc., who claim and cherish warmly their association as graduates with this University. In honoring them the University will honor herself and cement still more closely those ties which policy, no less than sentiment, demand should be drawn ever closer and closer. We are glad to learn that this sentiment is being fully recognized by our authorities, and that the occasion will partake in so large degree of family felicitations and filial appreciation.—*Old Maryland.*

BALTIMORE CITY AS IT APPEARED AT THE FOUNDING OF THE COLLEGE OF MEDICINE OF MARYLAND IN THE EARLY PERIOD OF THE NINETEENTH CENTURY.

MARYLAND
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THE ADMINISTRATION OF ETHER BY THE DROP METHOD.

By S. Griffith Davis, M.D.
Anesthetist to the Church Home and Infirmary.

On reviewing the current medical literature I find an enormous amount of material on the subject of anesthesia and on the verious methods of administration. None of the methods suggested, however, can approach the drop method if it be properly applied. The vapor method as described by Gwathmey in the *Journal of the American Medical Association,* October 27, 1906, with a few improvements in his apparatus and by preceding the ether vapor with either nitrous oxide or kelene, will in all probability be the only method that can in any way approach the drop method.

About a year and a half ago I first saw the drop method, during a visit to St. Mary's Hospital in Rochester, Minn., where it was so skillfully administered by Miss Alice Magaw and her assistant. Later I again was impressed with its merits by seeing it used at the Mercy Hospital in Chicago, where it was equally well administered by a Sister of Charity. I have seen it administered in various other institutions, but, unfortunately, in many instances new interns were given the very responsible duty—a duty only secondary to that of the operator. In these cases the anesthesia was poorly given and the true merit of the method inadequately demonstrated. Too much importance cannot be given to the anesthetic.

We often fail to appreciate the responsibilities of our positions when we have the patient's life absolutely in our hands, frequently hovering between life and death. That the patient should be in a certain state of anesthesia is of great importance to the operator, and in many instances the success of the operation depends quite as much upon the anesthetist as upon the operator. We can readily see that if the surgeon is working in the pelvis or abdomen and the patient is not kept thoroughly anesthetized the contraction of

the abdominal muscles antero-laterally and the diaphragm above causes the intestines to force through or around the packing and to obstruct the view of the field of operation, and even serious complications may develop. If there is an infected area the healthy intestine will become infected and the patient may be lost from general peritonitis, due solely to the lack of skill of the anesthetist. In a case of simple appendectomy if the patient is not relaxed there is great danger of gas and of particles of fecal matter being forced into the cecum, and the stump of the appendix may open after it has been sealed with the clamp and cautery before the surgeon has had time to apply the sutures. Here again there will be great danger of peritonitis, and the loss of the patient will be due not so much to the operator, but to the anesthetist. If the surgeon is working in the cranial cavity it is most important to keep the patient quiet and free from cyanosis. Suppose the patient should choke, cough, become black in the face, the small veins that did not bleed and would not ordinarily give any trouble now bleed freely, and consequently the surgeon would almost have to abandon the operation or the patient might die without warning. So it is with operations on the eye, such as iridectomy; a slight motion of the patient may cause the loss of an eye.

It has been my custom during my nine years of work at the Church Home and Infirmary to ascertain the condition of the patient before the administration of the anesthetic. Always make yourself familiar with the thoracic and abdominal examination. Always learn fully about any pathological condition of the blood or urine. Examine the air passages for obstruction, such as false teeth, gums, tobacco, etc. New growths in the nasal cavity or malformations may cause serious obstruction to the free entrance of air. Frequently the malformation of alae of the nose act as a valve to shut off the free entrance of air.

One of the most important procedures is to gain the confidence of the patient. Make him or her feel that they are absolutely safe in your hands and tell them how to breathe and what is expected of them.

For several years it has been my custom to put a piece of rubber protective over the patient's eyes to shield them from the ether vapor. Since adopting this method I have not had a single case of ether conjunctivitis. The face is protected with a moist towel or gauze, which extends over the rubber tissue and around the chin. The apparatus usually employed for the adimnistration of ether is a wire frame, patterned very much after the Esmarch chloroform inhaler, made larger in order to give more space under the inhaler for the mixture of air and ether. The outline of the mask curves to fit the face closely. The wire frame may be covered with one or two layers of stockinette or several layers of gauze. I have found by experience that the air space under the frame should contain about 25 cubic inches—that is, about three times larger than the ordinary Esmarch's chloroform inhaler. The best covering is about six layers of ordinary gauze, which can be quickly

applied and thrown away after being used. The wire frame should be boiled immediately after use. The mask is applied over the patient's face and the ether dropped on drop by drop, very slowly at first, then gradually increasing as the patient is able to take the stronger vapor. Finally, about the time he will not respond to questions, a moist towel or gauze is wrapped snugly around the mask, leaving a small area in the center for the free passage of air through the gauze. By this method the air is prevented from escaping around the edges of the mask and is made to pass through the ether-laden gauze. The ether should not be dropped on faster than the patient can comfortably breathe it in. Patients should, preferably, be anesthetized on the operating table. Such cases as are too nervous to be taken to the operating-room can be put on the table in the anesthetizing-room and rolled into the operating-room after the anesthetic has taken effect. The anesthetizing-room should be kept absolutely quiet, no unnecessary talking, slamming of doors or heavy walking, as all sounds are very much magnified to a patient who is about to pass into the second stage of anesthesia. Never be in a hurry to put the patient to sleep. Do not let an impatient operator worry or hurry you on, but remember that the welfare of the patient, yourself and frequently that of the operator depends upon the slow and gradual ratio of the increasing concentration of the ether vapor. The patient will become unconscious in two or three minutes, and should be ready for the operator in about 10 minutes. When a patient has become completely anesthetized, very little ether, dropped slowly, but continuously, will suffice to maintain the proper condition.

The further efforts of the anesthetist should be devoted to observing the respiration, pulse, pupils and the patient's general condition, and to prevent him from passing into that dread stage of respiratory paralysis. The respiration should be quiet, with perhaps a very slight snore. Panting and rapid breathing, irregular stertorous breathing indicates that the patient needs more air. The pulse should be regular, full and bounding. The pupils should be normal in size, quickly responding to the light. A pupil that is rapidly dilated indicates danger, and an immobile dilated pupil indicates extreme danger.

Of the 2000 recent ether anesthesias in the Church Home and Infirmary 1500 were given by the old-fashioned crural cone method, 500 by the drop method; 100 of these were kelene-ether sequence; about 200 of those given by the cone were chloroform-ether sequence. Since adopting the open method I have discarded the chloroform-ether sequence, as I was not able to detect any advantage in it over straight ether. A patient can be put to sleep as quickly, and perhaps with less inconvenience, with the ether dropped on rather cautiously as with chloroform. Of the 100 kelene-ether sequence the patients have gone to sleep promptly, without any unpleasant sensations, in from 30 seconds to one minute and a half. Those who have taken nitrous oxide say the

kelene is more pleasant, as they did not feel as if they were breathing "nothing," and surely they did not look as if they needed oxygen; on the contrary, they maintained a good color, with the face slightly flushed. Anesthesia by the kelene-ether sequence can be produced by one of two methods—the patient is fully anesthetized with the kelene administered with any good closed inhaler, such as the Hollenberger, Green or Wore-Stork, or for children the semi-open inhaler devised by Wore. Dr. A. E. Osmond of Cincinnati, uses an ordinary glass funnel with great success. During an expiration the ether work is substituted and ether continued by the drop method. The period of kelene anesthesia is of such short duration that the patient begins to loose the effects of the kelene before the ether anesthesia can be produced; consequently there is a slight disturbance and time lost. In order to overcome this difficulty I had Gwathmey's gas-ether apparatus so modified that the kelene can be gradually discontinued and the ether slowly substituted by the closed method. In two or three minutes the patient is fully etherized. Then the ether is continued by the drop method. As a rule, just enough ether is given to keep the patient quiet and relaxed. A majority of the cases begin to wake up before leaving the operating-room. Many of the anesthetics were given for Dr. Thomas S. Cullen, who in all abdominal cases orders a one-quarter grain of morphia before the patient leaves the operating table. These patients usually sleep for several hours, awakening with comparatively little nausea. I find there is a great deal less vomiting after the drop method. After an abdominal operation the patient is given plenty of water, so that if vomiting does occur the water brings up the mucous; if no vomiting, then any mucous in the stomach is at once carried by the water into the intestines.

THE DISPENSARY TREATMENT OF NEURASTHENIA.

By William Rush Dunton, Jr.,

Assistant Physician, the Sheppard and Enoch Pratt Hospital, Towson, Md.

The treatment of neurasthenia has always been a long, tedious task, taxing the patience of both physician and the subject, and it is only in recent years that the treatment of these cases seems to be getting shorter in duration and less taxing to those concerned. As most of my medical work has been in a hospital for the insane, where the patients, in addition to neurasthenic symptoms, usually have some mental trouble, the treatment of these cases did not follow the exact technique as laid down by Weir Mitchell, but was subjected to certain modification on account of the necessity of paying primary attention to the treatment of their mental symp-

toms. The duration of the treatment at best seemed to me to require from three to six months, frequently longer; to require services of a special nurse, and isolation was essential; the patient could not be treated at home; and, above all, bed treatment was necessary during the first part of the treatment. It was about six or eight years ago that I first began attending the neurological dispensary at the Johns Hopkins Hospital, and in the beginning the idea of treating cases of neurasthenia seemed to be almost hopeless, with the preconception that I had that these cases required the rest, isolation, special nursing and all the other appurtenances which are, as a rule, so expensive. It was my first opportunity to treat neurasthenia uncomplicated by marked mental symptoms, and I was very glad to have this experience. I inherited a number of cases from my predecessor, and these I found were being treated with tonics and partial rest in bed and forced nutrition. As a rule the patient was not allowed to get up until after breakfast; a cold sponge bath was usually ordered in the morning, and they were directed to eat frequently during the day.

In observing these cases I found that after a period, usually equivalent to the time required for the cure of a case of neurasthenia in a hospital—that is to say, from three to six months—they showed marked mental improvement, and this encouraged me so much that I sought for other means to extend the treatment and make it of greater value. The cases which I class as neurasthenics are those which show a morning tire, a lack of appetite, insomnia and anesthesia to fatigue—that is, signs of fatigue come on abruptly after a prolonged physical or mental exertion, during which time the patients have not been conscious of any fatigue, and these signs of fatigue usually occur abruptly and severely when they have finished the task which they have been performing. These, I think, are the cardinal symptoms of this condition, and associated with these there is frequently a feeling of anxiety or even depression, which was explained usually by the fact that the patients were wage-earners and could ill afford the time necessary for them to come to the dispensary for their medicine, so that the question of their stopping work in order to take the proper rest treatment could only meet with a negative answer. Naturally, this feeling of depression militated against the success of the treatment, and when we met with a case who was obliged to keep on with his or her daily work, working at hard manual work from 7 to 6, with an hour's rest daily, the prognosis seemed almost hopeless.

I do not claim any originality for the treatment which has been adopted, as it is the outcome of the experience of my colleagues and suggestions from them. We have all labored together for the success of treatment in the dispensary, and are glad to adopt any suggestions which we feel would be of value.

Whenever it is possible for the patient to take a rest, this has been ordered, but in only about one case in twenty has this been

possible. In such cases the patient is encouraged to remain in bed until about 10.30, after which he is to arise, take a sponge bath, which is at first given warm and the temperature decreased daily until it is that of ordinary tap water; his breakfast is served to him in bed; he is to take a lunch immediately after rising, which may be of milk, with bread and butter, or sometimes bread and sugar or bread and molasses; in fact, almost anything that is palatable to the patient and will increase his nutrition. He is directed to eat his three meals daily and to take a lunch such as I have mentioned in the middle of the morning and in the middle of the afternoon and before going to bed. If the patient is a beer drinker he is encouraged to keep on taking a pint of beer at bed time, as it is felt that it is a good hypnotic to those accustomed to using it, and its withdrawal will be apt to increase any insomnia which may be present. The use of spirits, however, is condemned absolutely, and the patient is only allowed the use of beer at bed time. As a medicine we give syrup hypophosphites, or if there is some dyspepsia we usually give the alkaline gentian mixture. Directions are given to take food slowly and see that a proper amount of fluid is taken daily. If constipation is present this is corrected by some purgative, although, of course, we try to correct this by patient's diet and by regular habits at stool. Psychotherapy plays an important part in the treatment, and we find that by encouragement and our interest in the patient's case he becomes less pessimistic and makes a greater effort to get well. Frequently the patient is told to indulge in a certain amount of social relaxation and to attend the theater once a week, avoiding emotional dramas and seeing the lighter plays or vaudeville. This is especially true in cases where there is slight depression and where the patient is apt to be given up to morbid introspection. The patient is told that he can be cured provided he co-operates in carrying out all the directions, and he is also told that if he looks at matters with a cheerful face recovery will be more rapid, and that his state of mind helps a great deal in carrying out the treatment and in attaining recovery.

The results of this treatment have been most encouraging, and there are but few cases whom it has not benefited, even in men who are at hard manual work. Its success, however, depends upon the patient's co-operation and upon his carrying out the directions. Half-way measures do not succeed.

I have been so encouraged in the dispensary treatment of neurasthenics that I have brought forward the subject tonight, hoping that I may encourage those physicians who, like myself, were pessimistic about this group of cases as not being amenable to cure unless we have an expensive armamentarium in the way of hospital treatment or isolation at home with special nursing. I believe that almost all cases of neurasthenia who undergo treatment early enough and co-operate in the therapeutic measures proposed will eventually recover, and that those who do not must be classed with the congenitally weak.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

MINUTES OF THE MEETING OF THE

ALLEGANY COUNTY MEDICAL SOCIETY,

HELD APRIL 2, 1907, 2 P. M., AT MOREHEAD HALL, CUMBERLAND, MD.

Dr. William R. Foard, *Secretary.* Dr. S. A. Boucher, *President.*

PROGRAM.

Regular order of business.

Papers with report of cases—

Cholelithiasis—Diagnosis and treatment.—Dr. E. B. Claybrook.

Diptheria, with report of cases.—Dr. J. H. Carpenter.

Personal experiences with abortion, and treatment.—Dr. T. Griffith.

A committee was appointed to look into the feasibility of renting a house, or rooms, to be used as a permanent meeting-place for the Society, and open at all times to its members. The Society to hold a meeting each month, with a program arranged six months in advance, along the lines of post-graduate work outlined by Dr. McCormack.

One new member, Dr. M. Catherine Buell, Cumberland, was admitted.

HARFORD COUNTY MEDICAL SOCIETY.

THE Harford County Medical Society met on Wednesday, April 10. Dr. James Bordley, Jr., of Baltimore read a paper on "Throat troubles and their relation to other diseases."

Dr. Emory was unable to be present, so his paper on "The treatment of goitre by the milk of a thyroidectomised goat" was read by title.

Dr. Charles Bagley, Jr., was admitted to membership.

The secretary distributed cards for subscription to the new library building.

A committee was appointed to make arrangements for a meeting in Havre de Grace in May.

DR. R. S. PAGE, *Secretary.*

SOMERSET COUNTY MEDICAL SOCIETY.

The regular spring meeting of the Somerset County Medical Society was held at Crisfield, Md., on Thursday, April 4, at 3 P. M.

After reading the journal of the last meeting the president, Dr. Chas. W. Wainwright of Princess Anne, delivered his annual address, and spoke especially of professional jealousies and the evil they worked among the members of the profession.

He then introduced Dr. John S. Fulton of Baltimore, who spoke very entertainingly on typhoid fever from the standpoint of a health officer.

Dr. Chas. T. Fisher read an instructive paper on the etiology of typhoid fever, which was ably discussed by Dr. C. E. Collins of Crisfield.

He was followed by Dr. Wm. F. Hall of Crisfield, who read an interesting paper on the diagnosis of typhoid fever, which was discussed by Dr. G. E. Dickinson of Upper Fairmount, Md.

Dr. Somers closed the subject with an interesting paper on the treatment of typhoid.

The subject of life insurance was introduced by the president, who had a set of resolutions read, which were unanimously passed.

Whereas, recent official investigation into the management of the affairs of the three great life insurance companies of New York have developed the fact that the medical departments of these companies were among those that were not honeycombed with corruption and fraud; and

Whereas, in our judgment, the steps taken to cure these evils are such as would tend to lower the standing and character of the work that is done by medical departments of these companies, and work an injustice to the policyholders and to the examining physicians; and

Whereas, the financial condition of these companies, notwithstanding the inroads that were made upon their treasuries by an unlimited amount of mismanagement and reckless waste of their funds, have shown by an enormous accumulation of surplus that economies are not necessary; therefore, be it

Resolved, That we, the Somerset County Medical Society, unite with our brethren of this and other States in protesting against the reduction of the examining fees in these companies; and be it further

Resolved, That we pledge ourselves as a society of honorable and professional gentlemen to make no examination for any old line life insurance company operating in our several districts, or that may operate in same, requiring an urinalysis, unless said companies pay us a fee of not less than five dollars ($5) for each and every such examination; and be it further

Resolved, That a copy of these resolutions be sent to the Medical and Chirurgical Faculty for publication in the society jounal, and a copy be sent to the *Journal of the American Medical Association* for publication.

Signed by Drs. Lankford, Smith, C. T. and W. H. Fisher, Wainwright, Dickinson, Atkinson, Ward, Coulbourn, Hall, Simonson, Somers, Schwatka, Alexander, Windsor, Allen, Collins and Hoyt.

The various standing committees reported, after which the following officers were elected to serve for the ensuing year:

President—Dr. G. E. Dickinson, Upper Fairmount.
Vice-President—Dr. J. F. Somers, Crisfield.
Secretary and Treasurer—Dr. R. L. Hoyt, Oriole.
Member Board of Censors—Dr. Chas. T. Fisher, Princess Anne.

After adjournment the members visited the dining-room, where an enjoyable repast was partaken of.

PRESIDENT'S ADDRESS.

By Hiram Woods, M.D., Baltimore.

THE MEDICAL AND CHIRURGICAL FACULTY: ITS DEBT TO ITSELF AND THE PUBLIC.

Fellow-Members of the Medical and Chirurgical Faculty:

A year ago, when you honored me with election to your presidency, I was not only conscious of the honor, but sensible of its responsibilities. Our constitution compels the President to keep in touch with the routine work of the Faculty. But beyond constitutional requirements, a man would show his unfitness for the position if, after a little experience, he did not become intensely interested; if he failed to see the possibilities opening to us as part of the organized profession of the country; if he did not seek the comradeship and advice of his professional brethren in developing the Faculty's forces, and if this work did not become a labor of love. For the past three or four years your President has found it necessary to depart from the custom of a century in presenting at the annual meeting an address on a subject of scientific interest. The work of the year has furnished him with theme enough, and he has felt it a duty to present this work, with a forecast as to future usefulness. So I make no apology when I ask your attention to the past year's work and to some lessons which can be profitably gathered therefrom.

The first duty I assigned myself was to discover the basis of work left by my predecessor—condition of component societies and attitude of our members to our organization and its work. We have been for a few years, and still are, in a transition stage. We are passing from a period of individualism to one of co-operation, for that is what "organization" means. The old regime of county, city and State society, each under different organization, each independent of the other, each entered by a separate portal, exists no more. The change has caused regrets in some quarters, inconvenience, or possibly open individual revolt, in others; but it has been accomplished, and it has come to stay. Looking backward is useless; sulking in the tent while the procession goes by is worse; for it not only throws the individual out of line, but deranges the whole campaign. There is very little of the backward glance, while if the spirit of sulking exists it has the good sense to hide its head. This is the condition in which our former President's work left the Faculty. And let me say here, for myself, my successor and future Presidents, that the magnitude of Dr. Earle's work, its thoroughness and inspiration, have smoothed out rough places, put into the whole State organization the go-ahead spirit and indicated new lines of useful activity. If I rightly interpret the spirit of his administration, it embraced conviction that no chain is stronger than its weakest link. He worked on the links, and these links, or component societies in the counties, responded so well to his efforts that they are holding up their proportional weight of responsibility. They recognize themselves as part of

the Faculty, study its interests, and are ready to work for its good. A second feature of Dr. Earle's administration was recognition of the facts that standing still meant losing ground, and that the best way to promote interest is to make men integral factors in the work itself. He mapped out work enough to give something to do to every man who desires the benefits which can come only through professional co-operation.

According to the Directory of the American Medical Association, the number of physicians in Maryland outside of Baltimore city is 736. Of this number 447, or nearly 61 per cent., are members of their county societies. In Baltimore county the membership is 56, with the same number registered in the directory. Some live in Baltimore, so it cannot be said that every man in the county is a member, but it comes very near being unanimous. In Calvert county 9 out of 10 physicians belong to the county society; in Charles, 14 out of 16; in Montgomery, 27 out of 34; in Frederick, 49 out of 80; in Washington, 38 out of 63; in Garrett, 9 out of 13; in Somerset, 17 out of 20. I have selected these counties because they are, with the exception of Baltimore, remote from the city, and are thrown on their own resources. The greatest difficulty seems to be in Caroline county. There are 19 physicians there, according to the directory, but the society has had a checkered career, and has just reorganized. We in Baltimore have only a faint conception of the difficulties confronting our county brothers in society work. I met at Elkton in January a man who had ridden 10 miles through a snowstorm and traveled about 25 on train to attend his society meeting. The same spirit of self-sacrifice, or at least comfort-sacrifice, is found over the State. Turning from numerical strength to the character of work done in county societies, we find every reason for congratulation. Papers and discussions are of merit. They show men are thinking, and emphasize the need of increased facilities from our library here to give them the help they need and want. There are a few societies which have not yet gotten their machinery into smooth motion. The counties are large, and it is difficult for men to reach the meeting place. From force of habit the society always meets in the same place, and, consequently, the same men, and no others, attend. Owing to such conditions men have allowed their membership to lapse, and valuable workers are lost to the Faculty. While not the only county suffering from these conditions, Harford will serve as an example. There are 36 physicians here, and but nine are members of the society. These all live in or around Belair. In the lower part of the county, near Havre de Grace, there are many excellent men. Some means should be found to afford society advantages to men so situated. Meetings could be held at regular intervals in their district. Transfer to more accessible societies is permitted, and the district society of our constitution is another means toward this end. In States where these district societies have been formed men come in contact with their brothers, and societies which have not developed their own working strength receive the stimulus of

example. The transfer method has been used to a limited extent with us, but we have never formed district societies. I think conditions in some places are such as to make them desirable. After all, the secret of success is to present something which men want to hear. There is not a single county society incapable in its own membership of having continuously instructive meetings if some man or men will take the trouble to arrange a program. I have not attended a county meeting without bringing back as much as I took, or more. Dr. Brush in his presidential address two years ago spoke of what city doctors, with their available nurses' directories and drug stores, might learn from their self-reliant companions in the country. Men state experiences and observations which, if prepared before with a little care, would be of interest and use. Why are these observations and experiences not so presented? So far as I can see, only because it seems nobody's business to invite the men beforehand to get ready. The same state existed in city societies, and only a little energy on the part of the executive committee was needed to correct it. This is possible everywhere. The changed attitude of county societies to city men is of no little interest. During the winter the secretary of one of the county societies spoke to me of a coming meeting, and I asked him if he wanted a city man. He said he would let me know if he did, and would specify the man. He didn't let me know. Later I asked him if city men were welcome. His reply was, "Yes, if invited." I approached a member of a society in another part of the State on the same subject, and he gave me substantially the same information. Knowing that my first friend belonged to a society that had often asked help, and which, frankly, I thought needed it, I wrote for an explanation. This is what I got: "It 'kills' local effort to depend on outsiders; the city man rarely brings anything of use to us, but something to demonstrate our ignorance of specialties or surgery." I will quote farther from this letter: "If my patient needs a surgeon or specialist, he usually knows it and goes of his own accord. We have been preached to enough along these lines. If a city man will bring us methods of diagnosis or treatment which we can use ourselves, he is always welcome." The sign is a healthy one. Self-reliance and appreciation of useful instruction will elevate a society to the top notch. Add energy and enterprise in utilizing self-reliance and the character of county meetings and corresponding attendance are assured. There is, it is needless to say, a kernel of thought for the city man after he has received his invitation.

The A. M. A. Directory gives 1036 physicians in this city, the City Directory about 290 more. Of this number 489 are Faculty members. This is 47 per cent. of the A. M. A. total. There are registered in Baltimore 294 men who have graduated from Baltimore schools during the past 10 years. Exactly one-half of these belong to the Faculty. These figures deserve consideration. Many city Physicians who do not belong to the State organization are advanced in life, their professional habits fixed, and there is little hope of enlisting their interest in society work. But the case

is different with young men. Medical co-operation is the watchword of professional life. Ten years hence, when these young men are in the midst of life's activities and responsibilities, to be unconnected with the State Medical Society will be almost professional ostracism. Never in the history of medicine has the young graduate had as good chance for rapid progress as now. Every dispensary, hospital, laboratory, library, society meeting presents opportunities for observation, original work, study and presentation of his thoughts to trained and liberal-minded critics. Nay, more, the public itself is not so averse to recognizing young men as was the case in a preceding generation. Dr. McCormack told us that in Kentucky they put young men into the State society when they pass the State Board. I have tried to learn the attitude of young men toward the State organization. A member of one of our leading faculties told me there was, so far as he could see, no interest in State organization among young men, and no appreciation of the advantages of the library and of professional associations. Inquiry among young men partly confirmed this statement. I have been told by several that they could see no advantage in joining the Faculty, while others have gone farther and confessed a belief that the Faculty itself is an organization run by a few men for the benefit of themselves and a few others. I shall not stop to discuss the absurdity of this proposition, evidently the product of ignorance both as regards individual and co-operative progress. The point is that this ignorance and indifference exist. For the sake of the young graduate himself, the Faculty and the public, this condition should be recognized and means devised to correct it. McCormack traced a close connection between student life and post-graduate relation to the profession. If co-operation and professional association are important factors in medical life, and if, as we claim, the expenses of life are so great and professional remuneration, on the average, so small that a young man cannot keep up individually with professional demands, it is the duty of his teachers and advisors to let him know what provisions an organized profession has made to meet these needs for him. He should not graduate without knowing about an organization able to give him so much. But it may be urged that it is not the duty of medical schools to look after the interests of the State Medical Society. Nor is it if development of a society be the object. We have been to infinite pains to secure a strong organization. Why? As an end in itself or as a means to an end? If the latter, and if membership in the Faculty means elevating association and influence, is it going too far to suggest that our members who are teachers should point their graduates in this direction? While their lives among us are fresh in memory we may learn something from the example of two men whom we recently lost, one by death, the other by circumstance. On the 27th of last November our profession gathered at Emmanuel Church to pay a last tribute of honor and love to Isaac Edmonson Atkinson. In the throng were graduates of the University of Maryland back in the '80s, who knew that a strong, molding

influence had passed from their lives. This feeling was not confined to those who had the rare privilege of his personal friendship. It extended to men who had only heard him lecture, followed him through the wards, associated with him in societies or met him in consultation. He knew the value of professional association and society work. He urged this value on young men. The same lesson was taught by William Osler. No man equalled him in devotion to the Faculty and in efforts to enhance its resources for good. Modern medical organization, it seems to me, makes the inspiriting, optimistic influence which we gained from such men as these a general duty; for the growth of this spirit means not only prosperity for the Faculty, but the highest good for the individual. Graduates are strongly influenced in forming conception of medical life by the acts and words of teachers. The life of the graduate reflects creditably or otherwise on his alma mater. If medical organization is the path of progress, we promote the interests of the schools by teaching our graduates where this path lies. Medical organization has emphasized this as a duty the school owes students. We want to kill quackery. We migh employ educational prevention. Dr. McCormack impressed upon us the necessity of teaching students ethics. One school in Baltimore has, I believe, established a course of lectures to its seniors. The new code of the American Medical Association is based upon the old and somewhat drastic rules laid down in 1847, with penalties for violation. The modern code is little more than suggestive. The old principles are there, but practically unlimited freedom of judgment is given, and the main penalty for violation is loss of standing, save in cases showing moral depravity. The change is, in my judgment, essentially an advance in professional standards. Honorable, straightforward men need no rules. To formulate such as will keep others ethical is an impossibility. Will enunciation and explanation of the code of ethics have much effect on students? They know nothing of the exigencies of post-graduate life, and will regulate their future behavior according to environment and example. The time has come to establish a code of ethics in the student body; in other words, to impress students with the fact that they are, to quote the words of another, "already members-elect of an honorable profession," and are expected to live up to its code. In the last State Board examination two men were dismissed for cheating. I have no sympathy to waste on their detection, but I believe such a standard of honor can be established in our schools as will make it impossible for a cheating man to reach his graduating year. Human nature is the same in medical students as in other people. There are those who need no urging to be honest, some who prefer not to be, and a middle class which will go in the direction of least resistance. The two latter classes regard any system of watching in examinations as practically a challenge to outwit the watcher. The "honor system" demands, of course, strong sentiment in the student body. I cannot agree with those who hold that there is not sufficient "university" tone to the life in most of our medical schools to develop this sentiment.

It is based, after all, not on a distinctive university principle, but is an application of honesty to university life. It will not grow unless encouraged, for the up grade is harder than the down. Obtaining honest examinations for graduation and the State Board is a mere coincidence. The important principle is that honest professional relations are as applicable to students as to post-graduate life, and that if one is crooked the other is apt to be. Here is a practical something to take hold of when we teach students medical ethics. They should be told at the beginning of their course that they "have put away childish things" and are to be governed by mature standards of honor and behavior. Something might thus be done to abolish the annual autumnal spectacle when grown men are paraded about the streets in hazing sprees. Such things only bring the student body into popular contempt. Take the men into professional confidence; confess—what they already know, and we can find out if we do not—that no system of espionage can be devised which will prevent cheating. Some of our students come from colleges where the honor system holds sway. Such men can be made active factors with their teachers in upholding the morale of the school and in elevating student character. I have dwelt somewhat at length, gentlemen, on the personal element, because I believe that professional character is the basis of success; the best preventive of unethical behavior; its early development the surest way of stopping quackery; that if we and the public are to reap the benefits of medical organization, training of professional character should begin when the student crosses the threshold of his school, and that more is needed than enunciation of principles applicable to conditions he knows nothing about. He must see the application to the student life.

During the past year there have been opportunities to learn what our members think of our present organization. One feeling is, I believe, general: The membership wants full information about what is going on. Routine work is certainly best accomplished by a small body. Only harm could result from radical change in our constitution, and none, so far as I know, desire it. Yet there are certain things which by right belong to the entire membership. The general meeting elects the State Board of Medical Examiners. This meeting, it seems to me, should know directly from the Board about its work. For this reason, although the Board reports to the House of Delegates, I have taken the liberty of asking Dr. Scott, Secretary of the Board, to present this evening a résumé of its work. New movements, especially those which touch the Faculty's interest, public affairs and legislation, should be given the greatest publicity. Two committees were appointed at the last annual meeting, one on our relations to the lay press, the other on dispensary abuse. I have asked Dr's. Warfield and Thayer, chairmen of these committees, to report tonight. The greatest need at present is a new building. So important is it that the program committee has arranged for a special session here tomorrow evening, after Dr. Simmons' oration, in order to lay the matter before the whole Faculty. There is growing appreciation of the impor-

tance of organization. We are learning that there is more in it than formation of societies. Protection of our own interests is evidenced by the action of some of our component societies in opposing reduction in fees for insurance examinations. This movement started in the West, and has been generally endorsed the country over. But more important is the endorsement by our membership of national movements for improving educational standards, obtaining more profitable work in societies and securing greater influence in public affairs.

In this connection, without anticipating the reports which Dr's. Warfield and Thayer will submit, I want to say a word about the subject given their committees. Our relations to the lay press will, I believe, not become more influential until we alter our own conception of these relations. Newspapers are after news, and if we have a message of public interest they will deliver it. Note, for instance, the courtesy and activity of the city press in explaining the object of the McCormack meetings. But editors have learned the difficulty of obtaining information from our profession. Conservative men do not like to go into public print, and for generations we have been taught that such a thing is unethical. So it is if the motive be one of self-advertising; but if we want greater influence with the press, if we think the interests of the profession and public can be promoted by closer intimacy between the press and a representative committee from this Faculty, it will be necessary to do work among ourselves and, possibly, revise our ideas of medical ethics. The first thing is to seek the men who are generally visited by reporters for news. The latter gentlemen, if I am correct in stating their attitude, know where they can get what they want, and go there after it. Nor are the men sought of the class we designate as advertising doctors. When one of these gentlemen, whose position, official or otherwise, makes him sought after, sends a reporter to one of our members, information should be promptly and fully given. This also applies if the reporter comes directly to a physician known to possess information of public interest. Change of attitude in our thoughtful men will have little effect on the few—and there are very few—who are afflicted with newspaper infatuation. If it affects them at all it will be to their undoing, for the character and purpose of the interview will be apparent. Either we must give up all idea of better relations with the lay press, or men capable of giving information of public interest must be willing to give it, and they must be held blameless by their professional brethren when they give it. The other feature of this committee's work was to seek from the press exclusion of advertisements of proprietary medicines, so many of which have been proven to be either inert or injurious. In other cities a great deal has been accomplished with the best papers; but Mr. Bok tells us that this has largely come about through influences with which the profession has nothing to do. The exposures in *Collier's Weekly* and *Ladies' Home Journal* have aroused public sentiment in some places to such a height that subscribers have written to or interviewed publishers

and secured withdrawal of pernicious advertisements. Mr. Bok calls on us to cleanse our own journals before we go to the press. I have followed with great interest the work of the lay press committee, and my conviction is that if we want better relations, we must alter our own ideas and educate our patients.

Dr. Earle in his address a year ago spoke of dispensary abuse, and at his request I presented to the general meeting a paper upon the subject, discussing it, in the main, from one point of view—admission to dispensaries of unworthy applicants and means hitherto employed to prevent imposition. I stated my conviction that none of these means had been effective; that most of them had introduced new forms of abuse as offensive as those they were to remedy; that no *one* institution could do the work single-handed, even in its own administration. I see no reason to revise any of these opinions. The suggestion was made that co-operative study of the question might lead to a solution. A committee was appointed to "investigate the extent and possibility of correcting the dispensary evil." Dr. Thayer's report will, I believe, show what a difficult and far-reaching problem has been given the committee. There is not even a consensus of opinion among ourselves as to what constitutes dispensary abuse. Men view it from standpoints as wide apart as the poles. Sociological conditions among the masses cannot be neglected. Educational and clinical equipment among ourselves plays an important role. To accomplish anything worth working for, charity organizations must be called to our aid. Behind all there must be, as I stated a year ago, general desire in the profession to remedy *something*, and consensus of opinion as to what we wish to remedy. Farther study may settle the latter. At present it seems to me uncertain if a definition of dispensary abuse can be given which will be so generally approved as to form a working basis. I hope I am mistaken. I think, however, that the State Faculty is hardly the body to make this investigation. It belongs more properly to the city society.

The State Legislature will meet in January, 1908, and it is not inappropriate to consider briefly measures which the Faculty may want to present to that body. The first and most important step is to determine what we want, to be agreed upon it, and be ready to act when the time comes. Some of our failures in the past have been due to poor preparation and lack of accord among ourselves. It will be recalled that in the fall of 1905 consideration was given to amending our practice act. Everybody interested in the matter knew the present law was not all that could be desired, but it seemed impossible to settle on measures which were generally approved. The House of Delegates finally decided to drop the matter altogether. At the last annual meeting the committee on public policy and education was directed to "arrange for such changes in the medical laws of this State, to be presented at the next meeting of the Legislature, as shall bring these laws in full conformity with the requirements of this minimum standard." The "minimum standard" referred to was adopted by the American Medical Association upon recommendation from the Council on Medical Education, and is as follows:

"1. *Preliminary Training.*—A high-school education or such education as will admit the student to our recognized universities. This requirement to be passed on by specially-designated State authorities, such as the superintendent of public instruction or his representatives, and not by the faculty of the medical school.

"2. *Medical Training.*—A four-year course in a medical college, each year of at least 30 weeks, with 30 hours per week of actual work (exclusive of holidays), no two courses to be taken in the same year. This course to be approved by a conference between the Council on Medical Education and the State and Territorial licensing boards and college authorities.

"3. The graduation from such an approved school should simply entitle the candidate to an examination before the State Examining Board.

"4. The passing before a State Licensing Board of a satisfactory examination and the securing of a license to practice."

This will doubtless meet with opposition. There should be no difficulty in overcoming it, for it will come from sources which are a disgrace to the body medical. The courts have decided that the State Board must examine all applicants who are graduates of chartered schools. It is to be taken for granted that opposition to the measure will come from such institutions as will be practically closed by its adoption, for the preliminary training clause will, if enacted and enforced, deprive them of students.

Serious consideration should be given to methods of dealing with illegal practitioners. At present our State Board is doing splendid work in this direction. The effects of the Board's crusade are seen chiefly in the removal from the State of men trying to practice without meeting legal requirements. I do not know that the Board's activity in this direction is known and appreciated as it should be. Its members have shown earnestness and activity in furnishing the police with information looking to the detection of illegal practitioners and in prosecuting cases when found. It is hard, disagreeable work, such as less conscientious men might shirk without much risk of reproach. There are peripatetic individuals who have complied with requirements and who cannot be reached. They go into the counties, having previously announced their coming in the local papers. Complaints have come to the Faculty office about such persons several times during the past year. The profession should feel the responsibility of reporting all suspicious persons to the Board, so their legal status may be determined. I doubt if change in the present law is desirable. It was considered in 1905, but no agreement was reached. Enforcement will come only through our own watchfulness. The Board is not the only power which can prosecute offenders. A county society or individual physician may put evidence in the hands of the sheriff, who is compelled to see that anyone practicing in his district is registered. For some reason Maryland is regarded as a haven for quacks. Much of this might be corrected if the sheriff's attention were called to suspicious characters.

The evils of midwifery practice are well known. For some time a committee of this Faculty has been in existence, but has so far

failed to decide on measures to regulate this practice. At present there are on the statute-book three laws applying to midwives. One requires registration; but there is no legal right to inquire into the ability of women applying, and no power to prevent their practicing if they are ignorant, dirty or, it can almost be said, criminal; for it is next to impossible to obtain such evidence as will lead to conviction. Like most useless laws, this has fallen into disuse. The second law is part of the act passed in 1894, compelling midwives and nurses to report cases of ophthalmia neonatorum. In addition to reporting such cases, midwives are prohibited from applying remedies. The third was enacted in 1898, and requires midwives to report to physicians or the health officer fever and other phenomena occurring after childbirth. No penalty is attached for violation. In *Charities and the Commons* for January 12, 1907, is a most interesting article by Miss F. Elizabeth Crowell, setting forth the results of her investigations among the midwives of New York City. Conditions there are doubtless not very different from those which would be unearthed here if the same line of investigation were followed. Forty-two per cent. of the total number of births reported for 1905 were attended by midwives. There are about 1000 of these women in the Borough of Manhattan, and Miss Crowell interviewed 500 of them. She visited them in their homes, inquired into their outfit and examined their "bag." She found but 10 in the 500 whom she felt justified in classifying "capable and reliable"; 176 of the 500 she classifies as "criminal." The so-called schools for midwifery, she believes, are only diploma machines, which issue diplomas or certificates to women unable to read or write, but who have the price—$66. There are four such schools in New York. Some of these ignorant women, many of them probably criminal, held certificates from physicians. Even well-trained midwives from Europe had caught the contagion of slovenliness and had degenerated to the level of their American sisters. Miss Crowell (herself an experienced trained nurse, and formerly superintendent of St. Anthony's Hospital at Pensacola, Fla.) draws a few conclusions which are of serious import. She believes the midwife horror is a condition, not a theory; that the demand is such as to make the midwife a permanency; that neglecting or failing to recognize her can only result in entrenching her behind the bulwarks of popular ignorance and increasing her power for harm. She thinks there should be a law defining the province and duties of the midwife, providing ample punishment for violation of the limitations prescribed by such law, and requiring absolute evidence of professional fitness as a condition of licensing to practice. Four counties in New York State have special legislation regulating the practice of midwifery. They have, Miss Crowell thinks, largely eliminated the ignorant and incompetent midwife. So far as I have been able to discover, the one effort to curb the midwife evil in Baltimore has come from the Woman's Relief Association. This association employs a woman physician to attend such parturient women as apply, and provides a caretaker to look after domestic affairs during the lying-in period. This same association is arranging for a crusade

in Baltimore similar to Miss Crowell's in New York. What it will develop is in a measure unknown; but those of us who come in contact with the results of midwife activity have little hope that the Baltimore showing will be better than that in New York.

I have dwelt on this subject because I think it of vast importance. What can we do? The class of women who are midwives are, for the most part, so densely ignorant that they could not take instruction if handed out in its simplest form. At least a beginning could be made by securing legislation requiring them not only to register, but to show qualifications; by issuing a license from the health office, and by making this licence revocable on proof of lack of qualification before a medical tribunal; by making them responsible, or at least accountable, for bad results in their practice, and by prosecuting them if they step beyond the supervision of natural labor into the sphere of obstetrical practice. I am encouraged to think that an act based on such simple principles would eliminate some of the worst women, because I know that the ophthalmic law has wrought a great change in their state of mind. I have personally had four or five of them arrested for infringement of this law and secured conviction in each case. We get hold of the babies now before they are blind. Knowledge that they are watched has a good effect on these women. While recognizing the difficulties that beset our committee in formulating an act for the Legislature, I cannot help thinking and hoping that the committee will see its way clear to take at least a first step in January to stop the awful sacrifice of life which goes on annually.

Akin to midwife regulation is prevention of ophthalmia neonatorum. Our law of 1894 has done excellent work in securing for infants proper and timely treatment. But the percentage of blindness from this cause is still dreadful. Lewis of Buffalo has recently estimated it at one-quarter of all blindness. He is certainly not under the mark. Yet the disease can be prevented in about 98 per cent. of cases. The American Medical Association has now under consideration a plan to secure general adoption of some form of prophylaxis. That most generally favored is the use of a 1 per cent. solution of nitrate of silver, to be prepared in sealed tubes and distributed from the health office. I believe the use of such a prophylactic is practically free from danger, and I know from personal investigation that its universal use in Baltimore maternities has almost eliminated the disease. Prophylaxis of this kind should be made compulsory in all institutions receiving State aid. Its extension to midwife practice would, I think, be advisable, even with allowed for midwife ignorance. But of this feature I should want further knoweldge before definitely recommending it.

"The pure-food and drugs act," which passed the National Congress in June, 1906, not only applies to inspection of foods, cattle, etc., but materially affects medical practice. In its application to medicines it demands that all drugs and preparations recognized by the U. S. Pharmacopeia or National Formulary shall conform to the standards of strength and purity established by these now legalized authorities. And all other drugs and prepara-

tions must not fall below their "professed standards." If it is desired to place an official drug or preparation on the market that does not conform to the required standards, its deficiencies must be plainly and clearly stated on the label. The alcoholic strength of *all* medicinal preparations must be stated upon the label, no matter whether "official," "proprietary," "patent" or "nostrum." The same explicit requirements are made regarding any of the following: "Morphine, opium, cocaine, heroin, alpha or beta eucaine, chloroform, cannabis indica, chloral hydrate, acetanilid, or any derivative or preparation of such substances," nor shall the package or label "bear any statement, design or device which shall be false or misleading in any particular." This plain and truthful labeling puts the responsibility for prescribing or taking "proprietaries" or "patents" upon the prescriber or user, and forbids the making of false claims as to their effects.

The law, being an act of Congress, cannot be made to apply to articles produced and sold within any of the several States, but since it applies to the District of Columbia, to the Territories and our insular possessions, and since contraband goods may not be shipped from one State into another, the effect of the law will probably in a short time control all articles of food and medicines, excepting those produced in limited quantities within the State. Movements are already on foot in a number of the States to supplement the national law with State enactments of much the same character. This matter should receive attention from our committee on legislation. Our State law should be in conformity with national regulations.

Another national law of interest to physicians is the one making provision for the sale of "denatured" ethyl or grain alcohol free of internal-revenue tax, which is now $2.10 on each wine gallon. This means that ordinary alcohol which has been made unfit for use as a beverage or as medicine may be sold at its real worth as fuel for use in the arts and for manufacturing purposes. This is interesting to physicians, because we may expose a number of poisoning cases for a time, because of the fact that wood or methyl alcohol is used in denaturizing it. Under the name of "methylated spirit" this poisoned ethyl alcohol has been sold in Great Britain for some years. A number of cases of poisoning have followed its use as a beverage there.

The April number of the MARYLAND MEDICAL JOURNAL contained a useful resume of the "narcotic law" passed by our last State Legislature. Dr. Magruder has presented the matter so clearly that little more than reference is needed. Special attention should, however, be called to the fact that paregoric and laudanum may still be sold freely to anyone. There are certain restrictions regarding prescription-writing which should receive careful study from practicing physicians. This law, it will be recalled, was the product of the proprietary-medicine people as an offset to the effort of the medical profession to secure the labelling act. It does not go as far as we think it should. Whatever steps it is proposed to take should be carefully and promptly considered by our committee. Otherwise we will be caught, as we were in 1906, without

agreement among ourselves and adequate means of pressing our measures.

I am convinced that the profession should make a determined effort to secure greater working force for the State Board of Health. Dr. Fulton has kindly prepared for me a statement of the appropriations, duties and needs of the Board. "The total appropriation is $14,300. Out of this amount is paid the salary of a bacteriologist, a chemist, an assistant bacteriologist, an inspector, a laboratory clerk and four clerks in the executive department.

"The Board is directly charged with the execution of the sanitary laws of Maryland, and also with other laws having a more or less direct bearing on sanitation. In addition to the appropriations already mentioned there is an emergency fund amounting originally to $10,000, which may be drawn upon to meet extra contingencies, under the direction of the Governor.

"The appropriation on account of vital statistics is $1800. This work involves the collection of about 10,000 certificates of death annually, and about the same number of records of births, all of which must be classified, tabulated and used as a basis for statistical reports and investigations. The records on file in the office of the State Board of Health include all the births and deaths in Maryland, excepting those occurring in Baltimore city. In an address delivered in this city by Dr. Billings some years ago he estimated that the proper collection of vital statistics in this State would cost $20,000 annually. This appropriation always has heavy demands made upon it, and it is only with difficulty that a deficit can be avoided. Copies of birth and death records are demanded for insurance and many other purposes, and although the method of keeping the records has been simplified as far as possible, the search for records still involves considerable demands upon the office force.

"*Food and Drink.*—The appropriation on this account amounts to $2500. This is largely expended for the salary of the chemist, buying and collecting samples of foods, water, milk and other beverages and their chemical analysis. An appropriation of double this amount would probably be sufficient to secure for the State a pure and wholesome food supply. It is impossible with the present appropriation and force of men to do more than sporadic work in the examination of foods. It has been found necessary to devote practically all of the inspector's time to the examination of animals and meats. The State and the city each have a man available for this purpose, but it is impossible for them to get more than a certain proportion of unwholesome animals. It is probable that a force of five or six inspectors will be necessary to properly cover this portion of the work of the Board without reference to other articles of food.

"*Infectious Diseases.*—There is $2500 available for this purpose, the larger portion of which is expended in maintaining a biological laboratory. In this laboratory examinations and investigations are made by the bacteriologists in various infectious diseases throughout the State. The routine examinations include examinations of sputum for the diagnosis of tuberculosis, examinations of blood

for the diagnosis of malaria and typhoid fever, and the examination of throat swabs for the diagnosis of diphtheria. This department was established in 1898, and has been receiving a very greatly increased number of specimens every year. It is now a matter of great difficulty for the laboratory to keep pace with its routine work, and absolutely no time is available for very important special investigations. In addition to the examination of specimens for diagnosis, a constantly increasing number of samples of water must be examined from all parts of the State. Examinations during the year 1904 include 694 specimens of blood for typhoid, 249 for malaria, 444 examinations of sputum for tuberculosis, and 1056 diphtheria specimens. There were 159 water samples examined and five samples of food. Two examinations were made in the detection of rabies, and a small number of samples of milk were also examined. Many supposed cases of rabies referred to the Board were investigated by Dr. N. G. Kierle without charge.

"*Tuberculosis.*—There is an appropriation of $5000 available for the execution of the laws on tuberculosis. The largest part of this money is not expended by the State Board of Health, but is used to recompense physicians for measures of prophylaxis taken in the households. When the law was drafted it was estimated that the absolutely necessary measures of prophylaxis could be secured at a cost of $3 for each patient, $1.50 of which was to go to the physician. By great care and rigid economy the Board has been able to keep within their appropriation at a cost of allowing a very large part of what could be done along this line to remain neglected. It is probable that the Maryland law is as practical and efficient as any yet devised, but with an increased expenditure of time and money its efficiency could be increased many fold.

"*General Needs of the Board.*—The most urgent needs of the Board, as will appear from this abstract, are an increased force of men and a more liberal appropriation. Ten thousand dollars additional will enable the Board to do very thorough work and develop a very large field as yet untouched. There are only two executive officers on the Board, the secretary and the medical assistant. In order to maintain the efficiency of the Board the local boards of health should be visited by one of these officers several times annually. It is impossible at present to attempt this except in response to urgent appeals. A large part of the time of the executive officers must be spent in the diagnosis of infectious diseases and in making sanitary inspections about the State and dealing with various epidemics as they arise. A large portion of the time of any efficient board must be spent in receiving and giving out information. This must be largely neglected now, as the office force to handle it is not available. The making of sanitary surveys is a highly-important duty of the Board, which can only be attended to now in emergencies. During 1904 there were six such sanitary inspections made, all of which, to be properly accomplished, should involve from three days' to a week's work. The time is approaching very rapidly when, for the protection of cities, towns and scattered communities, provision for State regulation of water supplies and sewage disposal will be imperative. The laws of Ohio could

stand as a model for this form of work. The proper regulation of water supplies is only to be accomplished by constant inspection and examinations of the watersheds and collecting and distributing systems, which, to be done efficiently, would require the undivided attention of a special officer. In general, the sanitary laws of Maryland are at present very satisfactory, and all that is necessary is to provide means for their enforcement. Additional legislation is unnecessary. To illustrate more forcibly the needs of the Board, it might be advisable to compare the State Board of Health of Florida in the matter of their executive force and appropriation with that of Maryland. The population of Florida at the last census was given as 528,542, while that of Maryland was 1,188,044. With respect to money, Maryland could probably be estimated as ranking about four times greater than Florida. Florida has a special tax for purposes of hygiene, and the annual appropriation to their Board of Health probably averages about $50,000, as compared with about $17,000 for Maryland. They have five executive officers in their Board, as compared with two in Maryland. The amount of work accomplished by the respective boards could be put at a modest estimate of about three to one in favor of Maryland. The work of the Maryland Board is probably now arrested as far as expansion is concerned, and it is necessary to exercise great caution in handling routine matters for fear of exceeding the appropriation. As a matter of fact, the State has not paid any rental on the laboratory, which is used jointly by the city and State boards of health, for the past three years, as there has been no money to meet this charge. The Legislature should furnish not less than $10,000 additional annually to properly conduct the office of the State Board of Health. The State should provide an assistant secretary and a medical officer at a salary which would be sufficient to induce competent men trained in hygiene to remain permanently in office. The day has long been past when sanitary affairs can be conducted by amateurs in or out of medicine who have taken up hygiene as a sort of side issue. The salaries of the bacteriologist, chemist, assistant bacteriologist and inspector or inspectors should be taken out of the present appropriation of the Board and definitely provided for by law. A sum should also be provided for rent and office expenses, which now is drawn out of the general expense account."

In the few remarks I made at Annapolis last September I said that it was poor economy for the State to stint the Board of Health. The above account of the Board's responsibilities and needs demands no comment. But it is our duty as physicians to influence our representatives. As a profession we are stronger in legislative circles than we realize, provided we are united on a measure whose wisdom can be demonstrated.

I shall not dwell upon the work in progress to lessen the ravages of tuberculosis, for the subject will be presented during the meeting by those intimately familiar with it. One need I may mention in passing. Work, to be effective, must be done among *children* of consumptives. Workers in this field tell of the insurmountable

difficulties in getting these little ones into proper environment. There are the parks; but somebody has to take them, and car fare is not always handy among these poor people. The mother has home duties and cannot leave. Nothing is left but to turn the children into the streets and alleys, which is little improvement on letting them alone. Playgrounds in the center of our densely-populated districts are needed.

Of the present needs of the Faculty the overshadowing one is a new home. This must receive close and earnest attention at once. There is absolutely no room in which to do our work, and no possibility of material advance until we have adequate space. This will be made clear tomorrow evening, and I earnestly beg every member of the Faculty to stay to the meeting after Dr. Simmons' oration.

The addresses of Dr. McCormack pressed home some lines of work which had already been considered, and others whose possibilities for good we did not appreciate. Improvement of society proceedings has received serious attention from your officers this year, and communications were sent to component societies last June urging practically the same lines of work which Dr. McCormack presented. The courses of study to be arranged by the national association will be a great stimulus if they are adopted. Yet, as I have already said, the working material is at hand now. All needed is for the society to realize its duty to organize it. A committee on program should be in every component society, and it should be made up of young men. The secretary has enough to do, if he attends to his work, without arranging meetings. One of the strongest of the component societies in systematic work is the Allegany County. Interest has so increased that at the last meeting it was determined to secure a permanent home, open all day to the members. This is, so far as I know, the first move of the kind among our societies. It should be imitated, and with proper attention to scientific work it could soon be accomplished in many counties.

Dr. McCormack urged on us the importance of closer relation with the public. There is nothing new in this, but we will never do much until we determine the forms which this relation should take, and set about its accomplishment. He alluded to meetings with pharmacists, lawyers, teachers, women's clubs, charitable associations, public officials and, possibly most important of all, the poor in our city. The brief address of Mr. Joseph Packard, after Dr. McCormack, stated how widespread and dense is the ignorance of ordinary common-sense principles. Rev. Dr. Hussey, who followed Mr. Packard, threw light on the moral side of the question, while both gentlemen indicated how the medical profession is needed to help mental and moral educators in their work. The interest shown by the public in efforts we have already made proves there is a large field for us if we choose to see it. The Tuberculosis Exhibit and Milk Exposition indicated how ready people are to receive fundamental instruction. One of the most interesting parts of that marvelously interesting book, Leonard

Huxley's "Life and Letters" of His Father, is that devoted to Huxley's Sunday afternoon meetings for workingmen. He met these men at a time when they were free from work and in places where they could gather. He went to them. Halls were crowded in all parts of London, and the great master taught these ignorant men physiology. He gave them a thinking basis for facts they knew in a dim way from observation. The good such assemblies do is not confined to the poor and ignorant who hear the lecture. We have professional problems of our own, and not one of them is unconnected with sociology. I have alluded to the vast difference in our members' views of what we call dispensary abuse. Analyzed, this difference has its basis, it seems to me, in the writer's conception of our profession's relation to the poor and ignorant. With some this relation is one of charity, or free attention, for those who deserve it, elimination of those who really or apparently do not. Clinical material fills the horizon for others. Our own abuse of philanthropic opportunities and the contradiction involved in charging registration fees in a charity hospital are what others see in existing conditions. Intimate, personal knowledge of social conditions would go a long way in clarifying our ideas of this and other questions; for instance, our relation to the public press. We want to learn to "see ourselves as others see us." Again, active interest in our own affairs would be greatly enhanced if some of our own young men were turned out to study these medico-social problems. We have the men, and only request from the Faculty is needed to get them at work. But the good we can take to our community there is no way of estimating. Thursday afternoon you will hear from Dr. Morrow and two of our own workers about moral and social problems which touch our profession to the quick. We have waged war on the milkman, the polluter of watersheds and the maintainer of nuisances, but the great giant of social disease stalks through our city and State, physically and morally corrupting our youth and leaving diseased bodies, impaired minds and social misery in his tracks. We try to keep measles out of our schools; but there is not one of them, I venture to say, where the dangers of gonococcic infection do not exist; and we know its dangers are more far-reaching and consequences more dreadful than most of the diseases which keep children away from school associates. It is in our power to enlighten the ignorance so prevalent on this and other matters. I venture to suggest that the appointment of a committee on public instruction is a Faculty duty. The work lying at our door for such a committee would lead to the solution of many questions which we have long regarded as essential instead of symptomatic and which we have, in consequence, failed to solve.

If I may follow the custom of "summing up," the Faculty's debt to itself is steady work in component societies to develop their own force. Self-reliance is the foundation of progress; but it is to be distinguished from self-complacency. One's own limitations should be recognized, and help sought if it will be useful. We should develop the spirit of co-operation. Misunderstanding saps

strength. Criticism, based an inadequate information, is inconsistent with ordinary fairness. Knowledge can always be obtained by enquiry.

Our teachers should promote medical organization by instilling into students proper conception of their position as members-elect of an honorable profession, and should help young men apply principles of medical honor to student life. Much worthless and unworthy material will thus be eliminated. By graduation time students should know about the State Faculty, and how it can help them. The duty of improving the tone of our profession and eliminating quackery lies at the door of the individual. Legal machinery is adequate; enforcing spirit must come from us. We must develop work among our younger men and make them active factors in the Faculty's life. This should be done through establishing new lines of public usefulness and the study of medico-social questions.

To the public we owe something more than knowledge of disease. We should take the position of public educators in matters affecting public good and physical well-being. We should secure better relations with the press by giving it for deliverance to the public something worth knowing. Legislators should not be left to find information on medical matters where they can get it, but we should take it to them, and use our influence as a united body. All this, at least in my opinion, is only the logical sequence of medical organization. It is antagonized by traditional interpretation of medical ethics, to a greater or less degree. But we are living under a new code, which puts ethical responsibility on individual honor rather than on arbitrary rules. This must be the basis of medical organization; for if the factors are faulty the whole will be useless.

I fear, gentlemen, I have trespassed too long on your patience; but it is my desire to set before this general meeting as clearly as I can the condition of the Faculty and lines of useful work. The active participation in affairs of the Faculty which it has been my privilege to take for the past few years has taught me many things I did not know before, and I thank you for the opportunity of learning them. I can say for my associates who have conducted your business during the past year that each has done his duty and striven solely for the Faculty's good. No one indisposed to take this view of his office should accept election. There is not an office in the Faculty's gift which does not demand time and sacrifice; but if one will make the sacrifice he will find his reward in enlarged views of the possibilities of medical organization, confidence in underlying principles of truth and honor in his professional brethren, and conviction that it remains for us only to unite for co-operative work in order to find and grasp the reality of "Unity, Peace and Concord."

Society Reports.

BALTIMORE CITY MEDICAL SOCIETY.

SECTION ON CLINICAL MEDICINE AND SURGERY.

MEETING HELD FRIDAY EVENING, DECEMBER 21, 1906, THE CHAIRMAN, DR. C. URBAN SMITH, PRESIDING.

The Mechanism of the Production of Hernia.—Dr. R. L. McNeer, Baltimore, emphasized the point that too little attention had been given to the elongation of the mesentery as a factor in the production of hernia. He considered it rare that any ordinarily well-developed person, free from disease, developed hernia unless there was a congenital defect. A person that attained his majority free from evidence of hernia and with well-developed abdominal muscles, unless there was a protrusion of the peritoneum following descent of the testicle, would not develop hernia. In the great majority of cases occurring in apparently well-developed persons there was some congenital defect about the ring. Relaxation of the abdominal muscles from any cause was favorable to prolapse of the mesentery and was a predisposing cause in the production of hernia. A congenital weakness was the chief predisposing cause, and prolongation of the mesentery was to be regarded as a factor.

Dr. Pearce Kintzing, discussing Dr. McNeer's paper, also considered a congenital defect necessary for the production of hernia. In his investigations he had been surprised to find the large number of males in whom the ring was open to the extent that the finger could be introduced to a considerable distance. In a large proportion of people with no hernia the finger could be introduced to a considerable distance. He had recently examined a man in whom, after reduction of the hernia, the finger could be pushed away up into the canal. He had recently seen a patient with a reducible hernia on the right side. On the left side there was no hernia, but the ring was patulous. Three months later on examining him a small hernia was found on the left side. The patulency of the canal was the chief factor. He also agreed with the writer that elongation of the mesentery played an important part in the production of hernia.

Dr. A. K. Bond referred to the relaxation of the abdominal muscles as a factor in the production of hernia, and thought it important that physicians should pay more attention to the strengthening of these muscles in cases predisposed to hernia by the employment of gymnastic exercises, deep breathing, etc., to tone up the muscles, especially where the patients had reached the age where but little exercise was indulged in ordinarily. They should be taught to take up regular, systematic exercise. Especially should deep respiration be insisted upon, as but few people used the abdominal muscles in respiration at all.

Dr. C. Urban Smith said in relation to congenital defect as a factor in the production of hernia that he had happened to see two families whose history was interesting in this connection. In one the grandparents, parents and six of seven children had hernia, half of them having double hernia. There could be no doubt of the hereditary tendency in this family. In another family both mother and father had double hernia and four children had single hernia. In none of them did the hernia appear until after 18 years of age. Where such a tendency existed it might be possible to do much to prevent its production by proper systematic exercise for the development of the abdominal muscles. He had frequently observed this hereditary predisposition and thought in such cases they should be cautioned of the danger and advised to pay attention to the development of the abdominal muscles particularly, and to be careful in their selection of an occupation.

JOINT MEETING OF THE SECTION ON CLINICAL MEDICINE AND SURGERY AND SECTION ON NEUROLOGY AND PSYCHIATRY.

MEETING HELD FRIDAY EVENING, JANUARY 12, 1907, THE CHAIRMAN, DR. C. URBAN SMITH, PRESIDING.

The Treatment of Neurasthenia in the Dispensary.—Dr. W. R. Dunton. (See page 174.)

The Relation of the Reproductive Organs to Hysteroid Conditions.—Dr. G. J. Preston considered hysteria a syndrome complex, and thought each one must decide for himself just what he would call hysteria. The usual symptoms were referred to, but Dr. Preston thought the term not at all exact for describing them, though in view of its ancient origin it was probably best to place these symptoms under that title. The term hysteria had been applied to all sorts of symptoms supposed to have their origin in the uterus, although many of them occurred as frequently in men as in women. There was, however, a close relationship between the reproductive organs and hysteria, as evidenced by the hysterical symptoms presenting themselves at puberty, at the menstrual period and during pregnancy. In the vast majority of his patients with hysteroid symptoms there was a close relationship of the symptoms to the condition of the reproductive organs. Although neurologists had of late years tended to deride such relationship, he felt strongly that it was a very close one. He felt that it was probably due to the effect upon the system of some internal secretion of these organs.

Symptoms and Treatment of Psychasthenia.—Dr. L. F. Barker, speaking upon this subject, said that psychasthenia was a term recently made familiar to us to cover the symptoms of obsessions, mental manias, agitations, anxieties, phobias, etc., which were all well known to us, having been frequently described under various headings. This term served to bring them all under one name. He considered this a great gain, inasmuch as a patient having one of these symptoms would be likely to present some of the others.

He had had the opportunity during the past two years to study a great many of these cases, and had found that by analyzing and comparing these symptoms it was easier to make a diagnosis, form a prognosis and institute proper treatment. Certain common characteristics were found in nearly all of them. The theory had been advanced that this whole group of symptoms was due to lowering of the psychological tension, and the theory of treatment was that we could get rid of the symptoms by elevating the psychological tension.

With the mental agitations were generally feelings of insufficiency and inadequacy. One of the most important symptoms in all these cases of psychasthenia, underlying them all, was the disturbance of what is known as the function of the real, the present, the concrete. He was inclined to give first place to this symptom. It was of great importance to study how to bring these patients back to a proper understanding of the concrete. It was a periodic disease. When the psychological tension is low the patient enters into a state of this kind; when normal he becomes more like the normal individual. Among the obsessions were a feeling of shame of self, as shown by a patient, a boy, who after taking a bath would spend hours in the bathroom cleaning the tub, and who felt all the time that he was not clean enough to associate with people. The imperative idea, as shown in a patient who felt that he must commit suicide; who had packages of chloral hidden about his person, but who never made any real attempt at suicide. Phobias, as the fear of a certain number. A patient feared the number between 12 and 13, which he could not bear to hear mentioned. The same man had absurd doubts about certain things. He feared to put the left foot out of bed first for fear that something might happen to him. Other phobias were the fear of cats, the fear of people, fear of getting into a carriage, fear of a certain disease, etc. There were, then, anxious feelings, feelings of disquiet, feelings of restlessness, feelings of physiological or psychological incompleteness; circulatory, digestive, or genital incompleteness; incompleteness in action, in intellectual occupations, in emotions; lack of ability to make decisions; feelings of discontent; necessity of having someone dominate them, to tell them what to do. One of the most interesting is that they feel that things are not real, or are not what they used to be; insufficiency of emotion, indifference to things; irresolution, timidity, fear of trying new things, were all evidence of a disturbance of the will.

Speaking of treatment, Dr. Barker said that if the patients were taken at the beginning of these symptoms much could be done towards restoration to health. The outspoken obsessions were the most difficult to deal with. Psychotherapy and re-education were the most promising forms of treatment. The rest cure without attention to these requirements was insufficient. They must be re-educated, especially as to the function of the real. They must give themselves up for a certain length of time, and medical obedience must be enforced. The patient must be dominated absolutely by the doctor, and gradually this medical absolutism should be replaced by self-direction along the same lines. The main thing to be held out was the possibility of their being masters of themselves if they were willing to be.

At the beginning of the treatment it was most important to get an avowal from the patient, and generally some mental or physical shock would be brought to light. A frank avowal was of the utmost importance. The physician must be the confessor and moral director. These patients were now coming more and more to the physician for such confession and direction, and he must learn how to listen to them without injuring the self-respect of the patient, and know how to utilize their confessions to direct them into the proper paths.

The Diagnosis of Neurasthenia.—Dr. John K. Mitchell, Philadelphia, deprecated the usual treatment of the neurasthenic patient with ridicule and telling him that there was nothing the matter with him. He defined neurasthenia as a chronic psychologic fatigue, due in part to malnutrition and in part to overexertion, occurring in persons with a predisposition, hereditary or acquired.

In the diagnosis the history of the remote beginnings or causes was of vital importance. It was generally a moral or mental strain of some kind. Among the symptoms the first and most constant was that of fatigue. Lassitude was constantly present; weariness was not relieved by rest. Second, irritable weakness, nervousness. Third, disorders of the will, such as indecision, inability to originate or hold to a line of thought. Fourth, symptoms of depression and anxiety. These different groups would, of course, often overlap, but some of them must be present for diagnosis. With them there should be little difficulty in diagnosis. A fifth important symptom in the diagnosis was absence of any organic disease so far as could be determined. Lastly, the state of mind of the patient as to his relation to the real world. He considered neurasthenia almost impossible in any but those who lacked all-round development of the mind, who were deficient in what we call logic. Then the fact that nothing but neurasthenia could produce such a multitude of symptoms and of such contradictory nature was also of importance in arriving at the diagnosis. Only two distinct diseases were likely to be confused with it—early locomotor ataxia and early paralytic dementia. The eye symptoms should distinguish the first and the medical symptoms the second. From hysteria, except where the two were complicated, diagnosis should be possible by the absence of crises, nervestorms, etc., the usual stigmata of hysteria.

Treatment consisted in repairing the damage caused by overexertion and in getting rid of the depression. This called, of course, for ingenuity. The most important thing was to strengthen the will and control moral habits. The first requirement was met by rest and psychopathic treatment and the second by education of the will and resisting powers of the patient. The kind and amount of rest should be regulated according to the special case. In slight cases isolation was not necessary; where there was much depression it was most important. Referring to the after-treatment of these cases, he believed in keeping the patients under observation for some months or a year until their equilibrium was firmly established. He advocated hard physical training in some cases.

THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY.

MEETING HELD DECEMBER 3, 1906—DR. BARKER IN THE CHAIR.

Exhibition of Cases.—Dr. Cushing. Case 1. This was a good illustration of a decompression craniectomy. A man 61 years old; good habits and health until last summer, when he was seized with severe headaches, both frontal and occipital, and chiefly nocturnal. There was also more or less dizziness. On October 9, after considerable exertion, an intense headache with nausea began. He recovered from this with a marked sensory aphasia. His eye-grounds were examined two weeks later and choked discs were found. On November 13 a simple decompression operation was performed, the seat of the operation being under the left temporal muscle, which overlies a relatively silent area of the brain, and where a consequent hernia would not be serious. There is now only a slight bulging over this area. The headaches have entirely subsided, and likewise the nausea and other symptoms. The choke disc is gone and there is an enormous increase in the visual field. There is still a slight trace of aphasia, but it is rapidly disappearing. There is, however, a permanent quadrangle hemianopsia.

Every case of brain tumor should be operated on as soon as the diagnosis is made, especially if choke disc is present. Fifteen out of 30 cases decompressed have been markedly benefited; in the other cases either the growth of the neoplasm was not stopped or an internal hydrocephalus developed. Do not wait for localizing symptoms before operating, for then the tumor has gone too far and the involvment is too serious.

Case 2. An old man 79 years old. He entered the hospital three weeks ago in very poor physical condition. He had had for 12 years a neuralgia starting in the second division of the trigeminal nerve. He had already had six peripheral operations performed, the average duration of benefit from them being about six months. He had suffered intensely and had had much drug-therapy. His arteries were extremely sclerotic, probably due to the neuralgia and not the cause of it; the painful impulses coming as severe shocks would cause a rise in blood pressure. Before the operation the blood pressure was equal to 190 milimeters of mercury, and with each paroxysm of pain it would go up to over 300, while at present it is only 140.

The scar of the operation is almost invisible, and the patient can wrinkle the forehead symmetrically. There was a modification of the old "horseshoe" incision in order to avoid the branch of the seventh nerve going to the occipito-frontalis muscle.

The operation was long and tedious, for the dura and bone were adherent; the ganglion was not removed, but the sensory part coming from the pons was evulsed and left turned up over the ganglion.

As a result of the operation a choke disc is always found, most marked on the side of the operation. The mere elevation of the temporal lobe during the operation causes an edema of the optic nerve; this disappears in

two or three days. There is a palsy of the sixth nerve on the right, but this seldom takes longer than three or four weeks to recover.

It is only in these cases of abducens palsy that a choke disc is seen after this operation, which inclines Dr. Cushing to think that the sympathetic fibers to the pupil travel by this way. It is very unfortunate to have to drain these cases, as was done in this instance, for it leaves the patient with a headache on the opposite side from the operation for a few days.

Case 3. This was the case shown two months ago by Dr. Thomas. For the past 10 years he has been having striking attacks of epilepsy, Jacksonian in character. They spread from the left calf to the left side of the body. There was some sensory disturbance. In 1903 he had symptoms which Dr. Thomas believed to be the acute symptoms of a brain tumor. Now there is optic atrophy with a narrowing of the visual fields.

On November 22, 1906, an exploratory operation was performed. The wound healed perfectly in spite of a long drainage, but under his right eye there is an echymoses, which is not uncommon following operative accidents such as happened here.

The longitudinal sinus overlies the superior part of the Rolandic fissure for one or two centimeters on each side of the midline. The foot area is, in this way, practically overlayed by the sinus. The superior cerebral veins run up, as a rule, over this area and go into the sinus one or two centimeters from the median line. Before this case Dr. Cushing had not succeeded in stimulating the area for the leg, but here a bone flap was turned back with the median point quite near the sinus, in spite of the fact that a continued oozing was obtained from points corresponding to the Pacchionian granulations. The patient took ether quite badly, and there was a great deal of uncontrollable bleeding from the granulations, so that the operation could not be finished.

In spite of the fact that it was considered dangerous to close the wound entirely with so much oozing, it was done, however, and the patient carefully watched. Up until 3 o'clock on the following morning, however, no untoward symptoms were observed. At that time the pulse was 64 to the minute. An hour later it was 56, and a rhythm of the pressure was found in accordance with the respiration and pulse. The patient was in a stuporous condition, which soon became comatose. At 12 o'clock the patient was put on the operating table unconscious, and on opening the wound the bone flap was pushed up spontaneously and an enormous clot three centimeters in thickness and covering the entire area was removed, and the patient awakened immediately as though from sleep and said "Good morning."

One week later a second operation was performed and an attempt made to go into the area of the tumor. The dura was turned back and a very good view of the pre-central gyrus was obtained. On stimulation distinct movements of the leg and some slight movements of the foot were seen. No growth involving the motor area was found. The wound was closed without any further exploration, although it perhaps would have been advisable to have gone back to the sensory or so-called sensory area for examination there also.

Some Observations on the Action of Lipase—Drs. Loevenhart, G. Peirce and C. G. Souder. Six years ago Dr. Kastle and Dr. Loevenhart demonstrated that lipase is reversible in its action on ethylbutyrate; that is, it is capable of forming the ester from ethyl alcohol and butyric acid, as well as effecting its decomposition into these substances. Lipase accelerated the reaction in either direction. Later Dr. Loevenhart demonstrated lipase in greater or less activity in most of the tissues tested. This work suggested a simple explanation of the fat absorption from the intestine, its translocation and deposition in the tissues and its utilization during inanition. Later it (lipase) has been shown by Hanriot to be reversible in its action on monobutyrin, and others have the synthesis of triolein by the action of lipase. Up to the present work no extended study has been made to determine whether the hydrolysis of different esters by different tissues is always due to some enzyme or not. During this work of Loevenhart, Souder and Peirce two interesting problems arose, namely: (1) The effect of bile upon the hydrolysis of esters by pancreatic juice; (2) the action of sodium fluoride on the hydrolysis of the various esters. The general view of the function of the bile in the absorption of fat from the intestines has been that the bile dissolves the fatty acids formed and emulsifies the fats, and, therefore, that its action is simply physical. The solvent and emulsifying action has been attributed to the bile salts. Hewlett last year, in the J. H. H. Bulletin, made the observation that bile accelerates the hydrolysis of the water-soluble ester, triacetin by pancreatic juice 26 times, while pancreatic juice alone has comparatively little action on it. The action of the bile in this case could not be attributed to its emulsifying and solvent action. Hewlett believed the acceleration to be due to the lecithins it contains.

Loevenhart, Souder and Peirce have studied the bile salts, lecithin and bile on the hydrolysis of a series of esters by pancreatic juice. Their results are, in brief: (1) These mixtures all accelerate greatly the action of pancreatic juice on all of the esters studied. (2) The effects of these substances, especially the bile salts, vary enormously with the concentrations employed. Thus, the amount required to accelerate the action on triacetin has practically no effect on the hydrolysis of olive oil, and the quantity required to accelerate the action on olive oil greatly inhibits the action on triacetin. (3) The accelerating effect on the hydrolysis of one ester is no index of its effect on another ester. (4) The accelerations noted with lecithin and bile salts vary with different specimens of juice; in some cases the former, in others the latter, causes the greater acceleration. They believe that it is chiefly the bile salts that cause the accelerating action of the bile under physiological conditions, and agree with Hewlett that their action is not altogether due to their solvent and emulsifying action.

They offer no explanation of the mechanism of the acceleration noted in the hydrolysis of esters when pancreatic juice is mixed with bile salts, lecithin or bile.

As to the action of sodium fluoride on the hydrolysis of the various esters, Kastle and Loevenhart found sodium fluoride, 1:5000, greatly inhibited the hydrolysis of ethyl acetate and ethyl butyrate by the liver and pancreas. The idea in this work was to determine whether it retards the

hydrolysis of the higher fats as well as lower esters. All processes were retarted by the fluoride, but the concentration of fluoride required varied enormously with different esters. The acid moity of the ester determines the inhibiting effect of the fluoride.

The inhibiting action of the fluoride decreases with increasing molecular weight of the acid from which the ester is derived. Thus, hydrolysis of the esters of acetic acid is about 15 times as sensitive to the fluoride as that of ethyl butyrate, and the hydrolysis of ethyl butyrate 100 to 1000 times as sensitive as that of olive oil.

The hydrolysis of the lower esters is remarkably sensitive to the fluoride. Even in concentrations of 1:100,000,000 some inhibition is noted. When beyond the limits of inhibition acceleration was frequently noted. Similar facts have been observed in many other enzyme processes.

It was found that the ratio between the activity of the liver and the pancreatic extracts, when tried on different esters, was far from constant; in fact, it decreased in an orderly way with the increasing molecular weight of the acid from which the ester is derived. With ethyl acetate the liver was found in one case to be about 11 times as active as the pancreas, while with olive oil it was about one-seventh as active as the pancreas. This indicates that the ester-splitting enzymes of the liver and pancreas are different. However, the liver does not contain a specific inhibitor nor the pancreas a specific accelerator for the hydrolysis of the higher fats, as was at first suggested. This was proved by studying the action of a mixture of liver and pancreatic extracts on ethyl butyrate and olive oil.

It was also found that the pancreas of different inidviduals of the same species vary in their relative activity toward two esters, and much larger variations are noted when different species were studied. These variations are believed to be due to variations in the substances mixed with the enzyme. The same is true of the livers of different species.

It must be borne in mind in considering the identity of different enzymes that in all the enzymic preparations hitherto obtained we have, in addition to the catylitic substance or mixture of substances, *i. e.,* the enzyme, an unknown quantity and number of admixtures, the effect of which must for the present remain unknown. This admixture is often of the greatest importance. Thus the work of Magnus and the writers has shown that in addition to the enzyme the bile salts are essential in the hydrolysis of amyl salycilate by liver extract. The physiologist may look upon the bile salts as an essential part of the enzyme which hydrolyses amyl salycilate. Some acid is also essential in the hydrolysis of proteids by pepsin.

It is suggested that the bile salts and the acid, which can readily be separated from the enzymic preparations, should be called coferments. All of the hydrolytic enzymes at present known are destroyed by heat, are non-dialysable, and are catalylic in their action, as far as this has been studied. It is to such a mixture of substances that the term enzyme should be restricted at present, and the term coferment can designate those substances which fail to have any of the above properties, but which are essential to the action of the above group.

Cases of Thrombosis of the Posterior Cerebellar Artery—Dr. Thomas. Two years ago Dr. Thomas showed here a case of a patient with thrombosis of the posterior cerebellar artery, and last summer a patient died here in

the Hospital of the same trouble. The picture presented in a thrombosis here is one of a remarkable combination of symptoms. Dr. Thomas has collected 25 cases corresponding to this picture. It occurs usually in men somewhat above middle age with a sudden attack of vertigo and rarely loss of consciousness. There is a tendency to fall in one direction, a pain on the same side of the face toward which they tend to fall, and a difficulty in speech and swallowing. The initial symptoms last for a shorter or longer period; some of the patients were in bed for a year on account of the vertigo. The symptoms pass off slowly. On examination an interesting picture is found. If the patient sits up or stands he tends to fall always to one side. The visible perspiration is on the side opposite to that towards which he falls; he is apt to have a difficulty of speech from paralysis of the vocal cords on the side toward which he falls; there is also a certain amount of ataxia on that side and a contraction of the pupil there.

Sensory examination shows on the affected side a loss of pain and temperature on the face, and the same loss on the contralateral leg. Another common symptom is extreme singultis.

There have been seven autopsies reported besides the one of Dr. Thomas'. A thrombosis of the posterior inferior cerebellar artery is found, and a microscopic examination shows a softening in the mid-olivary region.

The history of the man who came into the Hospital this summer and died is as follows: He was somewhat of a nervous or hysterical temperament. Six weeks before admission he had an attack of vomiting. Three weeks later he had an unconscious attack, was unable to swallow or speak, and the pupil was smaller on one side, with a ptosis also on that side. On examination there was found thrombosis of the vessels of one leg; the lungs, heart and kidneys involved; temperature 100; sweating only on one side, on the opposite side pyosis and a small pupil, and a loss of pain and temperature. There was a marked arterial sclerosis, and the patient was somewhat out of his head. At autopsy there was found a thrombosis nearly everywhere, but no thrombosis in the posterior cerebellar artery as was expected. However, on microscopic examination this artery was found completely thrombosed, and a softening in the region just outside of the olivar region, in some places involving the olive.

The posterior inferior cerebellar artery passes off from the vertebral low down, passes around the crus and the region above the olive, where it has no anastimoses except with the same artery of the opposite side, and other small branches from the vertebral.

Mr. Burroughs, in some work done here, has found that by tying off this artery and injecting the basalar artery, every region but this region of the olivary angle is filled by the injected fluid. Among the interesting points to be explained is the crossed disassociated sensory distribution. Gowers tract, as is known, decuessates down below. Pain and temperature alone appear, for touch is brought up by other tracets. The ataxia with the fall to one side is a cerebellar ataxia and not a loss of muscle sense; the restiform body fibers are involved with the vestibular nerve. Many tracts run here in the olivary angle, among them the fibers running down from the red nucleus and the cerebellum. If the fibers of the cervicle sympathetic are cut we get one-sided sweating, etc., but we don't know to what the symptoms are due.

MEETING HELD DECEMBER 17, 1906—DR. BARKER IN THE CHAIR.

Exhibition of Cases—Dr. Barker. Case 1. A girl, 10 years old, admitted to the ward on December 3 with a slight pulmonary infection. Her family history is negative. She has always been a weak child; had the usual children's diseases. At five she had typhoid fever. Three years ago she had tonsilitis and pneumonia. She has had no chronic cough. On November 22 she caught cold; had expectoration and cough, but no definite chill. Her temperature on admission was 102, but it fell suddenly to 99, and in two days became normal. There was a leucocytosis of 17,500. On physical examination dulness and limitation of movement in the upper right thorax was made out. In the left axilla distant blowing breath sounds were heard. Pneumonia was first thought of, but as the signs did not change and the temperature came speedily down to normal, another cause was sought for the marked physical signs. On the left side there was a slight drooping of the left eyelid, the slit was narrowed, the eye was less prominent and the pupil smaller than on the right. A ptosis due to paralysis of the sympathetic was the first thought. On looking up the literature on this subject cases were found ascribed to trauma, and also to intrathoracic tumors. These tumors were of two sorts—from the esophagus and from the pleura. In this case the signs have not changed and there have been no tubercle bacilli in the sputum.

The mother said the patient had had ptosis and a small pupil since she was one year old. Syringomyelia was first considered, but no other signs were found on careful examination. Pressure from a cervical rib was the next thought, and an X-ray was taken, which revealed a remarkable condition. No cervical rib was found, but there was a marked lateral deviation of the spine to the right with the concavity to the left and down to the eighth rib. There was a displacement of the seventh cervical spine, the left clavicle was elevated and turned up, the heart was normal. In the upper thorax a mass was seen, well defined and clear-cut, and therefore stationary and not pulsating. It fills up the whole thorax to the upper edge of the seventh rib and was round like a cricket ball. On further examination the trachea and thyroid gland were found displaced to the right of the midline. The right radial pulsated normally, but there was scarcely any pulse in the left radial. The veins of the left arm, shoulder and chest were dilated, and the left arm was two centimeters larger than the right. The breath sounds over the left chest were fainter than over the right. Therefore, there was an intra-thoracic mass displacing organs, compressing the arteries and veins, raising the clavicle and compressing the sympathetic. (1) Against aneurysm is the age and the fact that the mass is non-pulsating, as shown by palpation and by the fluoroscope. (2) Cysts—They occur in young children, due usually to the communication between the trachea and esophagus. They are small, as a rule, and not recognized intra vitam. (3) Esophageal diverticula or carcinoma—The stomach tube passed easily, and there is no difficulty in swallowing. (4) Pleural sarcome—The age favors this, but the slow growth as indicated by the small pupil for nine years is against it. (5) Pteratoma or dermoid cyst, etc.—These may appear early or late. They are a fetus in fetu, a brother or sister of the patient. Dr. Morris has looked up the literature and has published a paper on Dermoid Cysts of the Mediastinum. Fifteen

or sixteen cases are reporteed, but in only three was the upper part of the lung involved. One case was very much like the present one. In none was there ptosis sympathetica. The pteratoma, etc., would be either solid or cystic, and a needle can be introduced to determine this. In this case we have made a tentative diagnosis of pteratoma. Cocaine dilates the pupil, and therefore the sympathetic paralysis is not complete.

Case 2. Man, 61 years old. Works in a chalk factory and has to do heavy lifting, raising an eight-pound dipper up over his head. He came in complaining of rheumatism. His first wife died of tuberculosis. He had had malaria, typhoid fever and pneumonia before 40, and influenza since then. He had gonorrhea 40 years ago. About 27 months ago he had pain and stiffness in the left wrist. About one year ago his right wrist, and later the smaller joints of the right hand, became involved. There was no acute inflammation, but they became slowly worse. There was very little pain when at rest. Physical Examination—Moderate arterio-sclerosis, emphysema. The blood count is normal; the urine showed some albumin and hyaline and granular casts. He had a chronic bronchitis and a slight fever, but his temperature is now normal. The Articular Side—There is an interesting type of chronic arthritis ordinarily classed as arthritis deformans. There is definite limitation of movement in left wrist, and even more marked in the right. Grating is felt especially in the left wrist. The proximal phalangeal articulation of the index finger shows a fusiform swelling. There is no lipping of the edge of the cartilage and no atrophy. This is a help in diagnosis. Over the styloid procass of the ulna and a little more to the radial side of the ulna is a curious tumor. It might be a lobular bursitis, but no such bursa is recorded. The sheath of the extensor carpi ulnaris is largely under the ligamentum carpi, so it could hardly come from it. The nature of the arthritis—is it gout, hypertrophic osteo-arthritis, atrophic osteo-arthritis, etc.? There have been no gouty attacks and no tophi. It is not the hypertrophic form, for there is no change in the cartilage. Nor is it the atrophic form, the worst form of osteo-arthritis, in which the skin is glossy and smooth, and there is an annular constriction at the joint line. The grating shows that there has been some disintegration. On looking at the X-ray of the left wrist one sees that the distal joints are all normal, the articular surfaces are normal, there is some rarefaction of the bones, probably due to disuse. At the wrist, however, there is marked disintegration. The cartilage is gone and there is beginning telescoping. The scaphoid bone is right up against the radius and ulna. The radius and ulna have a worm-eaten appearance, and the fibro-cartilaginous disc over the end of the ulna is gone, and the radio-ulnar joint is likewise gone. There is complete obliteration of the joint cavities between the small bones of the wrist. Is it an infectious arthritis? The patient has an endocarditis with a mitral insufficiency, and the arthritis is probably metastatic in origin also. He has had repeated pulmonary infection, emphysema and bronchitis, and this is probably the source of infection. But why should the wrists be attacked? The explanation is to be found in his occupation, since for 24 years he has lifted heavy weights, and therefore his wrists were predisposed to infection by their continuous use.

(*Continued in June Number.*)

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JOHN S. FULTON, M.D., *Editor.*

Associate Editors:

THOMAS R. BROWN, M.D. | HUGH H. YOUNG, M.D.
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BALTIMORE, MAY, 1907

THE FOOD LAWS. THE EDUCATIONAL VALUE OF THE LABEL.

THE national law on meat inspection and the food laws have already secured to the country substantial benefits in foreign trade. So far as foreign buyers are concerned the results are altogether satisfactory, but the benefits to American buyers are not unmixed, and in some respects are gravely questionable. Discriminating buyers of manufactured foods have good defenses against fraudulent and injurious adulterations. The label must be truthful—that is, as truthful as manufacturers' statements can be made by law. Only some sorts of lying are prohibited. The label must tell the truth about the principal ingredient or ingredients and about the coloring matter or preservative added to a given weight of each product. Outside these limits there is liberal room and little danger in untruthfulness. Some of the more daring manufacturers stated on their labels that the United States Government guaranteed the date upon their packages. The Department of Agriculture repudiated this pretense and prohibited the use of such labels. The Department is not always so sensitive. The "Little Green Stamp" was a great seller of "bottled-in-bond" whiskey, and the Government endured very comfortably the widespread pretense of distillers that the little green stamp was a governmental guarantee of purity of their liquor. The Federal Government does not guarantee the contents of any package or the truthfulness of any label. The Government undertakes to examine all the places where foods are prepared for market, and all the processes and materials, to prevent as far as possible the manufacture or sale of injurious or fraudulent products, and, where prevention fails, to punish violations of the laws wherever detected. If sufficient means are provided, this work is no doubt well done, and certainly the situation is very much better than it was a few years ago. Discriminating buyers will now form the habit of reading labels, and will grow familiar with certain words—"compounds," "blend," "substitute," "artificial," "preserved," "colored," "flavored," "mixed." It fairly choked the manufacturers to utter these words in print. The people, they said, would never buy anything visibly labeled with any of these subtle words, though the artifices which the words imply are wholly beneficent, they contended — too virtuous, indeed, to be published. But the public bought as before, showing no sensitiveness and possibly without noting the altered literature on the labels.

One may know nowadays, approximately, what the packed foods really are, and between the discriminating buyer, who is worth saving, and the indiscriminating buyer, who has not entered the way of dietetic salvation, the difference is that the discriminating buyer reads the labels.

But the Federal law does not apply to all food materials. Whatever is manufactured and sold wholly within the boundaries of a State is exempt from the provisions of the Federal statute and subject only to the State laws. That means practically no protection for Marylanders in the purchase of foods prepared by Marylanders for the local markets. In the operation of the meat-inspection laws this limitation strictly to interstate commerce has positive disadvantages so far as many local markets are concerned.

THE NEED OF LOCAL INSPECTION.

The Federal inspection inflicts appreciable loss on great packing concerns such as those in Chicago and Kansas City. It is but natural to suppose that large concerns would seek means of reducing this loss. Their method of procedure is logical and effective. They employ private inspectors who select cattle on the range and at the shipping points, excluding all animals which are likely not to pass the Federal inspection, so that the large packers receive only selected animals, and their loss at the hands of Federal inspectors is now very small. But this private inspection does not benefit the buyers, for it does not dispose of the inferior animals. The private inspection simply warns the farmers and drovers that the rejected animals have a doubtful chance of passing the Federal inspection, and the obvious suggestion is that they should be offered for sale in the places where no Federal inspectors are stationed. The culls of the farm and range therefore seek the market where there is no inspection or inadequate inspection. Any community which does not safeguard its own meat supply by its own inspection must therefore expect nowadays increasing numbers of inferior animals to be offered in the local market, and the local meat supply will deteriorate proportionately. These results must be expected in Maryland, for the inspection here is strictly confined to Baltimore city and is but little better than no inspection. Not a single town in Maryland, Baltimore excepted, has any sort of defense against this danger. Some of the towns do not know that they are defenseless and do not realize that they need any protection.

In respect to dressed meats and to manufactured foods the Federal laws have not diminished, but have increased the responsibilities of States. These laws are vastly profitable to the country, but these profits are chiefly commercial, though a considerable part of their value is in their educational effects upon American consumers. That discrimination by which these laws affect only the trade which seeks to cross State boundaries, and exempts all trade of narrower scope, serves to emphasize in a wholesome way that cherished doctrine of State's rights, which is most inspiring when it presents itself as a right and quite deflates the statesman when it appears as a duty. The situation now confronting us lays a strong accent on the need for food laws in all the States as good or better than the Federal laws.

THE ACUTE NECESSITY FOR DAIRY INSPECTION.

At present it is not difficult to find markets for inferior animals and meats, for the local inspection is very poor in almost all of the United States. Popular writers often characterize local inspection as farcical.

Lesser "Jungles" may be found in every State and nearly every city of the United States. Our Maryland inspection is not quite farcical. It realizes for the people such profits as ought to be expected, and is therefore worth what it costs. The collar and cuffs of a shirtless man mean hope or reminiscence of better things, and local inspection has, in general, about this value. But when States realize that the Federal inspectors and corporation inspectors have combined, effectively though not wilfully, to impose the cullings of the meat market upon negligent communities the shock will awaken such communities to the indignity, if not to the danger, of such a situation. Through such discipline we in Maryland shall achieve respectability. Increasing and increasing need—contrast added to contrast between us and our neighbors—at last, perhaps, uniqueness of slovenly inefficiency will compel us to look after our own slaughterhouses, animals and meats. That Maryland will not move in this matter before the necessity becomes acute is a probability deduced from our inaction on the problem of milk supply. For many years past neighboring States have been paying more and more attention to the health of dairy cattle. In Pennsylvania the inspection of dairy heards is very rigid. Animals which react to the tuberculin test are promptly excluded, but they are not destroyed. Where do they go? Into New York State? No. Nor into New Jersey, nor into Ohio. Into Maryland? Yes, and in greater numbers, because Ohio, New Jersey and New York exclude them. The Commissioners of the District of Columbia propose to bar from the District the milk of all herds which do not exclude the chances of tuberculosis by the systematic use of the tuberculin test. And the dairymen of Virginia and Maryland have joined forces in the contention that the tuberculin test sometimes fails, and that the proposed regulations are burdensome and unnecessary. In 1898 Maryland dairy farmers went to Annapolis to make this same ignorant, purblind protest, and their success in that year has remained undisturbed until this day because the people of Maryland are content with a milk supply drawn from herds which include, besides the tuberculous animals of our own stock, many of the tuberculous animals systematically sought out and expelled from Pennsylvania. When the District Commissioners enforce their regulations, as they certainly should, we shall have a still more definite rearrangement of the milk business in Maryland. Washington will be a more attractive market for high-grade milk, and Maryland towns will cheerfully take the inferior milk. There is not at this moment any sign that the people of Maryland resent the progressive degradation of their milk supply. If such a situation should become, even in a slight degree, unpleasant to the people of Maryland, the remedy is perfectly simple. Not a line of legislation is needed. It is in the power of any incorporated town in the State to impose on their dairymen the same conditions proposed by the authorities of the District of Columbia, and the State laws on dairy inspection are already sufficiently stringent if they were properly administered. In Maryland the milk supply is more uncertain in amount, in price, and in quality than anywhere north of the Potomac, and this is so not for want of legislation nor for want of means. It is so because the people of Maryland are either uninformed or indifferent about it.

Medical Items.

BALTIMORE.

Dr. John S. Fulton, for the past 10 years secretary of the State Board of Health, has resigned his position in order to become secretary-general of the International Congress on Tuberculosis, which meets in Washington in the autumn of 1908. The State Board of Health will elect a successor to Dr. Fulton on May 1.

Dr. C. G. W. Macgill died at his home in Catonsville on April 28. Dr. Macgill was born in Hagerstown, where his father, Dr. Charles Macgill, was a prominent physician. He began the study of medicine in his father's office at the early age of 18, and in 1856 he was graduated at the University of Maryland. He practiced in Hagerstown until 1862, when he became surgeon to the Second Virginia Infantry, Stonewall Jackson's brigade, and continued in the service until the close of the war. Since that time he had practiced at Catonsville, and had been long established in the highest public and professional esteem.

GENERAL.

The latest contribution to the etiology of appendicitis is that of Mr. F. A. Pond, who believes that the rubber commonly used to stop bottles and jars containing food and drink is the cause of intestinal catarrh and ulceration.

The board of regents of the University of Nebraska has recommended that the degree of LL.D. be conferred on Dr. James Carroll of the United States Army at the annual commencement exercises in June.

The new Mayor of Chicago, Mr. Busse, lost no time in appointing a new Commissioner of Health. Dr. W. A. Evans is the new Commissioner, and it seems reasonable to believe that the selection is a very good one. At any rate, a very good man has been chosen.

Illinois is about to legalize the unrestricted sale of "patent" medicines by itinerant vendors, giving complete liberty in this traffic to all vendors who will pay a State tax of $5 per year. Kansas will deal less liberally with traveling quacks. They are to pay a license fee of $50 in each county where they operate.

The National Association for the Advancement of Science some months ago authorized the formation of a Committee of One Hundred to work for the creation of a Federal Department of Public Health. This Committee of One Hundred met in New York on June 19 and effected a permanent organization. The president is Prof. Irving Fisher of Yale.. The vice-presidents are President Eliot of Harvard, Felix Adler, Dr. Wm. H. Welch, Dr. Lyman Abbott, President Angell of the University of Michigan, Miss Jane Addams of Chicago, Mr. Andrew Carnegie, Archbishop Ireland, Judge Lindsay of Denver and John D. Long of Massachusetts. The executive committee includes Professor Norton of Yale, Mr. Champe S. Andrews of New York, Dr. Richard C. Newton of Montclair, Dr. John S. Fulton of Baltimore, Prof. F. C. Westbrook of Minneapolis.

Dr. W. P. Spratling announces a prize of $500, offered by the Association for the Study of Epilepsy, for the best esay on the etiology of that disease. The prize is given by persons interested, heart and soul, in the work of the association, and the conditions governing the award are as follows: All essays submitted must be in English, written in a clear, legible hand or on the typewriter, on one side of the paper only, and they must not contain more than 15,000 words. Essays must be in the possession of Dr. W. P. Spratling at Sonyea, N. Y., not later than September 1, 1907. Each essay must be sent without signature, but must be plainly marked at the top of the first page with a motto and be accompanied by a sealed envelope having on its outside the motto on the paper and within the name and address of the author. All essays received will be placed in the hands of three physicians to determine their merit. Two of these physicians are members of this association, the third a member of the American Neurological Association. Announcement of the award will be made at the November, 1907, meeting of the association. The association will not feel bound to award the prize should no essay submitted be deemed of sufficient value to merit it. *Original research*

work into the etiology of epilepsy will be a leading factor in fixing the award.

The International Congress on Tuberculosis, which will meet in Washington in the last two weeks of September and first 10 days of October, 1908, will be, it is said, a very remarkable affair. The National Association for the Study and Prevention of Tuberculosis is the sponsor of the congress, having extended the invitation which will bring the congress to America in 1908. Mr. Roosevelt seconded the nomination, the Ambassador to France, Mr. McCormick, being his spokesman. This invitation was given in Paris in 1905 and was accepted with manifest enthusiasm. Mr. Roosevelt's action at that time was known to be unofficial, but recent events have tended to give the President's action official significance. The National Association for the Study and Prevention of Tuberculosis some time ago appointed a special committee on the congress. This committee consists of Dr. Vincent Y. Bowditch of Boston, Dr. Lawrence Flick of Philadelphia, Dr. Alfred Meyer of New York, Dr. Charles J. Hatfield of Philadelphia, Dr. Lawrence Litchfield of Pittsburg and Dr. James J. Walsh of Philadelphia. This committee elected as secretary-general Dr. John S. Fulton of Baltimore. Late in January the preliminary organization was begun by asking the Secretary of State, Mr. Elihu Root, to inquire of the several Federal departments concerning their interest in the congress and in the exhibition, which is to be held at the same time. Within a short time the Deparement of State had learned that seven out of the nine departments desired to participate in the congress and in the exhibition. On February 25 a memorial, asking Congress for the authority and the means to carry out this desire, was introduced in the United States Senate bearing the recommendation of seven Cabinet officers. This matter will come up as soon as Congress assembles in December. The Governors of all the States and all the State boards of health have been invited, and a majority have signified their intention to be represented in the congress. The committee's plans for the congress cover a period of about a month. They will have a course of 30 lectures in Washington, each lecture to be given by some distinguished foreigner. These lectures will be open to the public, and some of the lectures will be repeated in other American cities. They will also organize a very large exhibition, collecting illustrative objects in all parts of the world. This exhibition will be open to the public for at least three weeks. Prizes will be awarded for especially meritorious exhibits. The scientific sessions will occupy about one week. The foreign visitors are to be entertained in the more important cities of the country before and after the week of the scientific sessions. The National Association will provide a fund of $100,000 for carrying out its plans, and their success in raising this amount seems assured by the fact that $30,000 is already in hand. The subscribers thus far are Mr. Henry Phipps, Mr. H. C. Frick, Mr. George Blumenthal, Mr. Martin Mahoney, Mr. Wm. P. Henszey and Mr. T. H. Higginson. Some of the most distinguished students of tuberculosis in foreign countries have already signified their intention to come over, and the foreign members in general, it is said, expect the American congress to prove a distinguished success. There is no doubt that the event will have extraordinary interest for Americans. The congress is not likely to come to America again in the next 20 years. The medical profession alone should furnish from this country 5000 members, the veterinarians will furnish a lesser strong contingent. In this country the campaign against tuberculosis has so deeply interested the lay public, and especially the sociologists, that several thousand lay members can safely be counted on. During the month of these activities in Washington there will be no end of clinics and demonstrations given in Washington by distinguished men, and the medical profession and the medical colleges in easy reach of the Capital City will be strongly attracted. This enterprise offers to the medical profession and to the humanitarians of this country an unique opportunity to give a very strong and enduring impetus to the antituberculosis movement in the United States. This movement is already in a healthy state of progress, and if we utilize the approaching event to its utmost value we shall not only appear well in the eyes of other nations, but we shall spread saving knowledge and generate saving activity in every corner of our own country.

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THE HELPFULNESS OF ORGANIZATION.

By Joseph P. Remington, Ph.M.
Philadelphia

The old and trite saying, "Many men of many minds," is just as true today as it ever was, and a most interesting study it is, in considering the past, present and future of pharmacy, to note the development of organizations which have been helpful to the individual through personal contact and association, whereby men mutually gain strength, not only through the exchange of professional ideas, but through the hidden influences which we must all acknowledge are powerful in guiding our actions.

The founding of the American Pharmaceutical Association in 1852 was occasioned by the necessity for an organization to improve the quality of drugs entering our ports from abroad, and it is interesting, in this connection, to reflect that just about a half century afterwards the same initial cause has brought about a mighty revolution in medicine and pharmacy, through the passage, by the Federal Congress, of the Pure Food and Drugs Act, for its aim and purpose is not only the improvement of the quality of the drugs entering our ports, but it has the greater and more comprehensive purpose of improving the quality of drugs and preparations which are consumed by the 80,000,000 of people of these United States.

To have lived and helped, in even a small measure, in this great work during the last half century has been a privilege not lightly esteemed. The average druggist 50 years ago was a self-contained, opinionated little despot ruling over a miniature kingdom bounded by the four walls of his shop. In many cases he was an Ishmaelite, with his hand upon every man's throat and every man's hand upon his throat; too often his sole and only purpose was to get gain; with a book of private formulas, often written in language understood solely by himself, he was a devout believer in the art and mystery (particularly the latter) of his calling, encourag-

ing the belief among his patrons that there was locked up in his cranium salable knowledge of which he was in absolute possession.

It must not be supposed that there were not scattered here and there through the country men of high intellect and broad spirit, those who were willing to sacrifice private gain for universal good, but 50 years of organization and effort have wrought a wondrous change. The American Pharmaceutical Association stands today pledged before the world as the exponent of higher professional attainments by aiding in every way to make the acquisition of pharmaceutical knowledge free from and untrammeled by mystery and secrecy to all who are willing to give the necessary time, labor and thought to self-improvement.

The "old-time druggist," as he is called, being compelled to lead almost a hermit's existence, was loath to be convinced that he could ever leave his shop without risking not only the lives of his customers, but his own financial existence. It has been but a few years since, while present at a meeting in this city, I heard a Maryland druggist say publicly that he appreciated so much the value of his State organization that he had put a padlock on the door of his pharmacy and a sign in his store windows that his business was closed until his return from the meeting. Fortunately, it is not necessary now for many to make such a sacrifice to the value of organization. An incident occurred in my own city a few years ago which illustrates the same spirit. A highly-respected doctor, who practiced pharmacy, was thoroughly imbued with the idea that he must never leave his store for a moment if it were possible to avoid it, and this notwithstanding the fact that he had a capable son as assistant. A few words of invitation to attend the meeting of the State association soon to be held in a neighboring city brought the answer, not altogether unexpected, that he had no opinion of a druggist who would waste his time by such nonsense, and he was positively rude. A few days afterward, however, he opened the subject himself, saying that he was getting a little old and tired, and it might not be such a bad thing to go. The necessary arrangements were soon completed, and the greatest surprise at that meeting was the presence of old Doctor K.; he stayed the full time of the meeting (two or three days), and was generally the first to arrive and the last to leave all the functions, enjoying every minute of the time.

On the last day he asked one of the members to introduce him to a man who had read a paper on some practical subject, and in a few moments they were engaged in a lively discussion. Pausing in his remarks, he said: "I beg your pardon, but what is your name?" The answer came: "I'm Mr. ———." "Where is your store?" was the next question. On receiving a reply, he said: "Why, that is only two blocks from mine," and the old gentleman was, for the first time in his life, face to face with his lifelong enemy and competitor, his nearest neighbor. "Why," he said, "you seem to have had the same kind of troubles that have fallen

to my lot." His neighbor, who has from the first believed in organization, replied: "Why, of course, we all have difficulties, and what we are here for is to straighten them out." The two men struck hands and were ever afterward such good friends that the organization man subsequently bought his store. While this illustrates the personal factor, the greatest helpfulness of a successful organization, like the American Pharmaceutical Association, comes from the influence of the whole body in fostering reforms, defeating unwise or vicious legislation and promoting the passage of legislative acts which are beneficial to the profession and which protect the public.

It would be impossible to even name, in the short time at my disposal this evening, even a tithe of the valuable and lasting work of our association. One of the newer plans of extending the influence of the association was ably advocated by Prof. James H. Beal of Ohio. This was to form, in various parts of the country, branches of the parent body; this plan is being rapidly carried out, and I have much pleasure in congratulating the Baltimore branch of the American Pharmaceutical Association upon the success which has attended your organization, for your city has much to be proud of. It was here that the Father of American Pharmacy, William Procter, was born, and you have had a long line of able pharmacists who have labored earnestly and devotedly for the welfare of the parent body. Among these may be mentioned Prof. Israel J. Grahame, the friend and contemporary of Procter, whose work on percolation and other scientific subjects will always be remembered; Prof. J. Faris Moore, and the other sturdy ex-president, Joseph Roberts; another ex-president, the genial, talented John F. Hancock, the president of your association; and still another ex-president, Charles E. Dohme, who, with his gifted son, Dr. A. R. L. Dohme, has written so many valuable papers for the body; here also lives Professor Hynson, whose voice is ever raised in defense of the organization's best interests; my friend Gilpin, who supplies pharmacists with official drugs, and many others, but I have saved until the last the general secretary of the association, Prof. Charles Caspari, before whom must come every question affecting the organization. With such a history of the past and present achievements the outlook for the future success of this organization is most promising.

In every successful organization of any kind there should be a proper relation established between the old, the middle-aged and the young—the old men for counsel, the young men for work and the middle-aged for both, and if tonight I might be permitted to offer a few suggestions, I would say that one of the greatest needs of the parent body is the advancement of the middle-aged and younger men to positions of responsibility and trust. I do this without the slightest intention of unjustly criticizing the present work of the parent body, but have we not, at the present time, the best opportunity to interest the younger men in the branch organizations at least? And nothing will attract a young

man so much as to give him some work to do, and what better work can be done at present than that of furthering the use of the preparations of the United States Pharmacopœia and the National Formulary?

Since the passage of the Pure Food and Drugs Act by Congress on June 30, 1906, these two books have been made the standards of the country. A great movement, not only in our cities upon the Atlantic coast, but all over the United States, has begun, and committees are being formed to make physicians better acquainted with these preparations. Foreigners who are interested in the pharmacy of this country cannot understand the cause for this activity; they cannot see the necessity for sending out literature and specimens to the medical profession to introduce them. They say: "Why are not physicians familiar with them. The Pharmacopeia in our country is issued by the Government, and physicians are compelled to use preparations made according to the standards." They do not grasp the idea that the United States Pharmacopeia was for three-quarters of a century an *optional* standard; that, while it steadily gained in influence, the Government did not accept it as a whole until last year, and it is because it is the law book of the land that the manufacturers and pharmacists are universally interested in complying with its requirements. The possibility of prosecution and the payment of penalties for ignoring the standards has been all-powerful in bringing about this mighty change. Naturally, in some quarters an outcry is heard, criticisms here and there, and a rushing into print is observed, but with some a deep-seated resentment that at last they must obey and either supply preparations strictly complying with the Pharmacopœia and National Formulary or place upon the label the acknowledgment that, in certain respects, their preparations differ from the standards. The Food and Drugs Act has wisely adopted this plan in preference to a more drastic one, and the departments of the Government who are charged with the enforcements of the provisions of the act have declared that henceforth "the label shall tell the truth."

While manufacturing pharmacists and chemists, wholesale houses and retail pharmacists have been from the first profoundly moved, the medical profession has been strangely apathetic. The American Medical Association at the present time is engaged in a hand-to-hand battle with the proprietary and patent medicine interests. This representative body is hammering at the same problem in a different manner, but it may be said that its principal object is identical with that of the Food and Drugs Act. It is battling with secrecy and misrepresentation by drawing the line, as far as possible, between preparations which can be recommended to the medical profession and those which do not meet with their approval. How long! how long! will it be before the majority

of the physicians of this country will refuse to listen to the voice of a siren who has influenced them to prescribe preparations that they practically know nothing about, but which they are induced to try under the plea that it is something new and will do wonders, for have not certain members of the profession put into print their recommendations?

When to personal solicitation is added the presentation of a circular containing a great variety of printed prescriptions showing eligible forms of administering the proprietary product, the capitulation is complete. Evidence of the widespread custom of prescribing secret remedies can be easily adduced by inspecting the prescription files of pharmacists, which show, in many cases, a large proportion of ready-made prescriptions for what are technically known as "hand-me-downs." It has been my good fortune to be present at many of the meetings of the American Medical Association, and I have seen motions and resolutions presented before this body by a few members of the medical profession who have fought valiantly for a different order of things; I have seen such resolutions passed unanimously, and it would seem as if physicians were coming into possession of their own, but when the influence of the association had passed, and the echo of the voice of the advocate of reform had ceased, the resolutions were forgotten and the siren voice of the salesman of the proprietary prevailed. Many physicians in their own offices were willing to acknowledge that they did not care for the Pharmacopœia or the National Formulary preparations; they were going to prescribe whatever they wanted to. Besides, they did not have time to bother about calculating the quantities of the ingredients in the prescriptions. It would surprise nobody here to know that it is a common practice for some physicians to prescribe original packages of patent medicines, thereby putting the patient in possession of several undesirable levers; the patient is familiar with the patent medicine, probably has used it without success, and is naturally indignant when he finds that the doctor to whom he pays a fee knows no more about his case than he did himself. It may well be concluded that this patient will become a firm believer in self-medication.

I have a purpose in bringing a few of these important questions before you at this time, because never before in this country has such an opportunity presented itself for physicians and pharmacists to unite in a combined effort to correct evils. Medical journals have been filled for years with communications from physicians complaining of the nostrum and proprietary traffic. The need of the moment is for physicians to grasp the situation. Upon them will devolve the responsibility. Every effort is being made by pharmacists to supply physicians with samples and literature, and every wide-awake pharmacist should be ready to furnish immediately all of the official and National Formulary preparations, and this association stands ready to do its part to the uttermost.

A mighty revolution is in sight; the law steps in and demands that the truth be told on the label. Morphine, cocaine, heroine, hydrated chloral, alcohol and a number of other hitherto unsuspected ingredients must now be plainly indicated. Is it a wonder that there is a gnashing of teeth at the prospect of the future? The veil of secrecy, at least for those preparations containing dangerous, habit-forming drugs, is rent in twain. No longer will the mother who loves her child remain in ignorance of what she is giving her offspring. The percentage of opium or morphine, cocaine or hydrated chloral must be stated. Thousands of preparations containing alcohol must disclose to the ignorant or innocent the proportion which it contains. Upon the laity hereafter will be placed a responsibility, and to the physician now will be disclosed secrets which have heretofore escaped detection. The medical profession should be more deeply interested in this subject than any other body; but, as I said before, a strange apathy prevails. The efforts of many medical writers heretofore have had little influence with the public in discouraging the use of nostrums, because the public reasoned that the doctor had a personal and pecuniary interest in opposing the use of such remedies. Naturally, the patient reasoned: "Why should I go to the doctor, dance attendance upon him for a month, and pay his fee, when I can go to a drug store, or even a department store, and get a wonderful medicine which will cure my disease?"

The sustained efforts of true, fearless journals, like the *Ladies' Home Journal* and *Collier's Weekly*, have accomplished much by exposing the iniquity of certain proprietary preparations, and they have awakened a public sentiment which is sweeping the country with irresistible force; if we must have proprietary medicines, they must at least tell the truth upon the label. Why have not the physicians of the country realized the true conditions of affairs? Why do they not appreciate the merits of the non-secret preparations now officially recognized by the United States Government? Why are the majority not keen to acquaint themselves with these weapons ready at hand? If they are not prepared *at once* to cease prescribing proprietary remedies, let it be done gradually, but the time is here and now to get back on solid ground by prescribing only those preparations of which they know the proportions and ingredients, modifying them as their judgment dictates to suit the patient's individual requirements. While yielding to no other person my respect for the medical profession, I sincerely believe that all that is necessary is to convince the physicians of this country that there is a better way than that into which so many have fallen, and if these few words can have any weight in explaining to the medical profession the underlying principles of the present upheaval which are founded upon truth and the true spirit of science, I shall feel well repaid for the time which has been given and your kind indulgence to one who sincerely believes in the dawn of better days for both the medical and pharmaceutical professions.

Current Literature.

REVIEW IN NEUROLOGY.

Under the Supervision of Robert Reuling, M.D., Baltimore.

Cerebral Decompression. A Palliative Operation in the Treatment of Tumors of the Brain. William G. Spiller, M.D., and Charles H. Frazier, M.D. *The Journal of the American Medical Association,* September 1, 1906, Vol. XLVII, No. 9.

The authors begin their article with a general review of brain surgery more especially in its relation to the immediate relief of certain distressing symptoms, such as pain, etc. For instance, they find that in 1894 Annandale opened the skull of a patient whose symptoms were those of general brain pressure, and, although no special condition was found, temporary relief was marked. In 1889 Annandale removed a piece of bone from the skull because of intense headache, following an injury of the head previously. No abnormal condition was found, although the dura incised. The patient made an excellent recovery and was perfectly cured. Annandale remarked that when no localized symptoms of brain tumor exist an exploratory operation may be performed, and experience has been useful in taking off general pressure, and in a few instances has even been followed by shrinking or degeneration of the growth. Again, a growth may give rise to effusion or fluid or to hemorrhage, and the symptoms caused by these conditions may be at least temporarily removed by operation.

Sahli in 1891 spoke of improvement from palliative operations. The tumor in one case was supposed to be in the cerebellum. Vision improved and headache disappeared after a palliative operation. Sahli advises two trephinings, remote from one another, as they tend to give far more relief from pressure.

He mentions, however, that not infrequently after palliative opening of the skull acute prolapse of the brain may impair the function of the rest of the brain. He, therefore, recommends small trephinings in preference to large. Horsely thinks that some tumors are so interfered with in their nutrition by opening the skull and suddenly altering the pressure therein that they forthwith degenerate. In another of his cases the tumor at the time of operation was too large for removal, but the patient survived for over two years, with disappearance of the hemiplegia.

Horsely states that he has found in every case the effect of opening the skull has been to remove the headache, and, further, that in cases where it was known before operation that the tumor could not be removed, relief from severe pain afforded by opening the skull persisted until the patient died. At the Berlin Congress Horsely pointed out that opening the skull caused the swelling of the optic discs to subside and that the subsidence may proceed steadily to complete recovery, provided atrophy has not previously begun.

Jaboulay in 1893 obtained good results by trephining in a case of tubercle of the brain without opening the dura.

Caton and Paul trephined the skull in a case of acromegaly in 1893. The dura bulged in the opening. The operation relieved the headache, and the remaining three months the patient's life was comparatively comfortable.

Keen in 1894 reported on a case where trephining failed to disclose the tumor, but relieved the intense headaches. The bone was not replaced, and although the brain bulged greatly, headache and hallucinations entirely disappeared. He died four and a half months after the operation.

Bruns in a case of brain tumor, in which the tumor could not be found at operation, improved the patient's condition by opening the skull. By the end of the third week very little choked disk remained, attacks of blindness no longer occurred, headache and vomiting ceased.

Decompressive trephining, a term employed by Jaboulay, performed for brain tumor, according to this author, has proven to be of some benefit. He speaks of astonishing results produced by trephining in the cerebellar fossa in a case of basal tumor. The pain ceased and the vision improved. Jaboulay seems to believe that the relief in palliative operations is greater for tumors of the cerebellum and adjoining parts than for tumors of the cerebrum.

Broca and Maubrac ascribe to Horsely the honor of being the first to describe carefully trephining as a palliative operation in brain tumor, although scattered references to the subject are found in the literature, such as those reported by Annandale and Lister.

Sänger in 1894 reported two cases to show that under certain circumstances trephining is proper, even when a tumor cannot be removed. Of 11 cases in which a palliative operation was performed the symptoms were much lessened in 10. The time for operation that Sänger chooses is the beginning of impaired vision. When the opening is made over the cerebellum the dura must not be opened immediately.

In 30 cases of brain tumor studied by Leslie Paton that were operated on useful vision was saved in 22, and the vision was as good as before the operation in 18. It is impossible to draw conclusions regarding his cases in which a tumor was removed and those in which a palliative operation was performed. In the discussion following Paton's paper, J. S. Risien Russell said he had no doubt that trephining was of great value in saving sight. He never hesistated to recommend the operation, even in cases in which there was no chance of either localizing the tumor of removing it, for by relieving the intracranial pressure alone sight could be saved. It was usually necessary to open the dura in order to obtain sufficient relief of pressure to bring about a subsidence of the optic neuritis. Paton also expressed himself in favor of opening the dura, as he did not believe merely opening the skull was of much benefit.

[TO BE CONTINUED.]

The Neurons. Lewellys F. Barker. *Journal American Medical Association*, April 7, 1906, Vol. XLVI, No. 14.

It is, unfortunately, still true that the neuron theory is still without a satisfactory explanation, and although Dr. Barker's article will no doubt prove of special interest to those wishing to read a clear compilation of the work recently published covering this subject, and although the neuron theory promised to be cleared of much of mystery surrounding it by the work of Ramoñ y Cajal, von Leuhossek, Retzins, etc., during the last two years, the present day, however, still finds the important facts unexplained.

Of course, as we all know, the main question at issue is: (1) Do the minute fibers ending in the terminal buttons (as Barker calls them) form anastomoses with one another, and (2) do neurofibrils pass from the terminal "buttons" into the adjacent cell body or dendrite to form connections with the neurofibrils lying in the protoplasm there? Barker says, after studying the preparations in which the latest staining technique has been used, he fails to find them, nor can Ramoñ y Cajal, von Leuhossek, Retzins, von Gehuchten or Mahaim demonstrate them in their studies. Held, however, thinks he can demonstrate such communications, and Max Wolff holds a similar view. Ramoñ y Cajal is convinced of the separateness of the terminal buttons from the adjacent nerve-cell protoplasm, and he unhesitatingly assures us that not only is the neuron conception valid, but even the contact doctrine is better supported now than ever before, and Sherrington takes the ground that the cell membranes at the junctions of the neurons (synapses) may be of very great importance in the reflex process.

Barker finds on reviewing all the theories which have been advanced, with the aim of discrediting the views based on the findings of Golgi's method, one comes necessarily, as von Gehuchten has emphasized, to a double conclusion. First, none of the theories opposing the neuron conception has led to the objective demonstration of the existence of a real continuity among the nerve elements; and, second, there is a marked difference between so-called neuronists and so-called anti-neuronists in interpreting known facts. The former, faithful to the facts observed, declare that in their preparations they find only free ramifications, and, not being able to see intercellular anastomeses, they maintain that one should not admit that they exist. The opponents of the neuron conception affirm that intercellular anastomoses ought to exist, but not being able to demonstrate them, they themselves supply what is lacking in their preparations; using theoretical considerations and physiologic arguments as a basis, they construct the desired continuity out of whole cloth. Advocates of the neuron conception and of the contact doctrine naturally regard this negative result of the numerous efforts made to establish the continuity as a very convincing argument in favor of the real independence of the neurons. Opponents of the neuron conception think that continuity is a priori, so probable that those who deny it should bring the absolute proof that it does not exist.

A Case of Angiosclerosis Producing Motor Disturbance in the Upper Extremity. Wilhelm Erb. *Deutsch. Zeitschrift f. Nevenheilkunde,* XXX, No. 3 u. 4, 1906.

One seems to find in the last year or more considerable more attention given to the importance of various disturbances due changes in the vascular supply to nerves and muscles, and these studies have brought forth a considerable knowledge of various symptom complexes due to abnormal blood supply. Strange to say, the veterinarian was the first to fully appreciate certain intermittent paralytic states in horses due to disease of the veins or arteries. The following case is one in point, described by Erb, and illustrates a group of cases no doubt frequently overlooked by the general practitioner, especially the etiological factor. It would seem that were the latter appreciated more fully many of these cases would be amenable to proper therapeutic measures, especially when discovered in time and where the arterial disease is due to lues, etc.

Erb's case was the wife of a country tavernkeeper, 57 years old, who had suffered with diabetes mellitus for two years. The patient revealed a marked disturbance in arterial blood supply of the right arm, due to a total narrowing in calibre of the entire brachial artery. This pathological condition produced no apparent visable changes in the general appearance of the extremity, nor in its temperature, functions, etc. It was only after somewhat prolonged attempts at muscular exertion that the marked weakness of the muscles of the right extremity showed itself. This weakness extended to the muscles of the right hand and as muscular pains became apparent with the fatigue and increased with increased efforts at exertion. It was also soon evident that as the muscles became paretic there was visible disturbance in the blood supply of the extremity (vasomotor phenomena). The patient showed evidence of general arterial degeneration, so that there seemed little doubt as to the cause of the disturbance, it being, of course, evident that the sclerotic changes had advanced to apparently a more marked degree in the right brachial artery. Erb suggests the possibility of localized constrictions, perhaps at the bifurcation of the vessel or in its axillary portion. The possibility of trauma in these cases must also be considered.

* * *

Pathology of Paralysis Agitans. By Carl D. Camp. *The Journal of the American Medical Association,* Vol. XLVIII, No. 15.

The author has succeeded in presenting the present conception of the pathology of paralysis agitans in an instructive manner much that will be new to many readers, especially the more recent studies of pathological changes in the muscular system and the skin. The importance of the neuroglia changes are also gaining more consideration, especially the presence of proliferative and

other changes in the endothelical and spider cells and the relationship of neurofibril formation.

Camp classifies these pathologic findings, according to their locality, into (1) those in the nervous system, the brain, spinal cord and peripheral nerves; (2) those in the muscles; (3) those in the ductless glands.

The gross lesions in the central nervous system found by some of the earlier writers, which were regarded by them as the cause of paralysis agitans, are not now credited with such a relationship. At that time the difference between multiple sclerosis and paralysis agitans was not well understood. Almost every known degenerative change has been described as occurring in the central nervous system. Philip found degenerative changes in the Betz cells in the para central lobules, and his findings tend to strengthen the claims of Gowers, Bychowski and others that paralysis agitalis is a disease of the cerebral cortex.

Gordinier found changes in the motor cells of the cerebral cortex, but not so marked there as in the spinal cord. The Golgi stain showed the dendritic processes nearly normal. Degenerative changes have been described in the anterior horn cells. They were also frequently found to contain an excessive amount of yellow pigment. A long list could be made of cases in which the pathologic examination of the central nervous system was negative. Thus Koller cites the cases of Peträns, Olliver, Cohn, Charcot, three cases; Westphal, Simon, four cases; Bauer, two cases; Leroux and Weinkowitz.

Various changes have been observed in the peripheral nerves. Borgherim found in the vagus, median and external tibial nerves a hyperplasia of the interstitial tissue and increased vascularity. Joffroy reported a case in which paralysis agitans was combined with peripheral neuritis.

Camp has had opportunity of examining the material from 14 cases of paralysis agitans. In eight he was able to include the peripheral nerves and muscles and in two of them the ductless glands. That the author had an unusual number of necropsies is seen when one considers that Gordinier, writing in 1899, could find but 54 cases with necropsy in the whole literature, and of these only 24 had been examined histologically.

The ages of the patients at death in the author's series ranged from 45 to 75 years; the duration of the disease from two to 20 years.

Macroscopic examination of the central nervous system, including transverse sections, revealed lesions in only one case. Tissue was taken from the para central lobules, the pons, the vermis of the cerebellum, the medulla oblongata and from the cervical, thoracic and lumbar regions of the spinal cord. The anterior and posterior spinal nerve roots from the lumbar and cervical regions were examined separately from the cord in six cases; the posterior root ganglia, from the lumbar region, in two cases; the peripheral

nerves were examined in eight cases. The pieces were dehydrated in alcohol in the usual manner, imbedded in celloidin and the sections stained as follows: Thionin modification of the Nissl method for study of nerve cells, the Weigert and the Marchi osmic acid for degenerations, the hæmatoxylin acid fuchsin and the Mallory neuroglia stains. A summary of the author's findings show that the most constant lesion was a fibrosis of the capillary blood vessels of the spinal cord, which, by rendering them more prominent, caused an apparent increase in their number. The region of the posterior and lateral columns seemed to be the most affected. This lesion was present in 11 cases, in all of which it was an accompaniment of a general sclerosis of the blood vessels of the nervous system. The next most frequent finding was a diffuse overgrowth of the glia in the spinal cord, usually more marked in the posterior columns, in six cases. It was not confined to any system of fibers, and in but one case did it show the tendency to form islets about the blood vessels as described by Redlich. In no case was it shown that the neuroglia proliferation was more marked in the gray matter than the white portion. The Betz cells of the paracentral lobules were considerably pigmented in many cases, but only in four cases was the pigmentation very marked, and in only two cases were there any distinctly degenerated cells. The motor cells of the anterior horns of the spinal cord were excessively pigmented in six cases; in four they showed distinct chromatolytic changes, but the loss of the dentritic processes, with a consequent lessening of the richness of the dendritic plexus as described by Dana, was not observed. The perivascular spaces were widened in four cases, and in five cases numerous amyloid bodies were seen in the spinal cord. The cerebellum, pons and medulla were practically normal in all the cases in which they were examined, a moderate sclerosis of the blood vessels and a slight subpial proliferation of the neuroglia not being considered pathologic when found in aged persons. Bychowski gives the following reasons for his belief in the nervous origin of paralysis agitans:

1. A hemiplegic distribution of the tremor speaks for a cortical origin.

2. The tremor ceases during sleep; i. e., when the function of the hemisphere is least active.

3. When a case of paralysis agitans in which all four extremities are affected develops a hemiplegia, the tremor disappears on the paralyzed side.

4. The not uncommon combination of insanity, hysteria or brain disease with paralysis agitans.

5. The parasthesial and subjective sensations of heat and cold.

6. The constant failure of any change in sphincter reflexes.

7. The increased knee jerks. The knee jerks are, however, too variable in this disease to be used as an argument.

[TO BE CONTINUED]

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

NOTICE OF THE SEMI-ANNUAL MEETING.

THE semi-annual meeting of the Medical and Chirurgical Faculty will take place on Wednesday, Thursday and Friday, September 11, 12 and 13. It is customary to hold this meeting at some different place each year that affords a pleasant outing; this year an unusual opportunity enables us to visit the Jamestown Exposition and also hold our meetings.

The committee in charge will be able to charter a boat for our party, which will take us down and back and be our headquarters while there. The present tentative plans are as follows: To leave on Wednesday night and have our evening session on the water, allowing two full days and one night at Jamestown, and returning Friday night. Thursday being the 12th of September, it would be a special honor and privilege to be present at the exercises of Maryland Day.

The expenses of the trip will amount to $15 a person, including the trip both ways, stateroom, meals and admission to the grounds. As most of us contemplate a trip to the exposition, how much better it will be to go at this time and enjoy not only our meeting, but the exposition as well.

Accommodations on the boat are limited to 100 persons, so the committee must know as soon as possible how many are going. Early applicants will be assigned to the boat, and those applying after the first 100 will be accommodated suitably in other ways. Accommodations will be provided for ladies wishing to make the trip.

Members desiring special information or wishing to make different arrangements may communicate with the chairman of the committee on arrangements, Dr. G. Milton Linthicum, Professional Building.

THE NEW LIBRARY BUILDING.

Two years ago the Faculty appointed a committee to raise funds for a new building. Owing to circumstances which need not be related, this committee has not made any formal report of its work up to this time. A report was made to the Council in March, and the committee was reappointed with power to collect funds, purchase a site and to take whatever steps may be necessary to secure for the Faculty the much-needed new building.

The Building Committee wish to report to the Faculty that they have again undertaken a systematic campaign to secure a building, and ask the co-operation and aid of every member of the Faculty and all of their friends.

The committee is of the unanimous opinion that, before any outside aid can be secured, we must first demonstrate the interest which we all feel in this matter by substantial contributions to the building fund. We want every member to contribute as soon as possible all that each feels able to give and more. We wish to urge all members who have subscribed, but who have not paid, to send in the amount of their subscription as soon as possible. Every month a list will be published of such subscriptions as have been paid, but the name of the subscriber will be withheld should he wish his gift to be anonymous.

The report will be divided into two parts: First, the amounts subscribed prior to April 1, 1907, and second, the subscriptions received after that date.

The Building Committee consists of the following:

Dr. E. N. Brush, *Chairman.* Dr. H. B. Jacobs, *Secretary.* Dr. John Ruhräh, *Treasurer.*

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Dr. W. S. Thayer.
Dr. Charles O'Donovan.
Dr. A. P. Herring.

All communications and inquiries may be addressed to Dr. John Ruhräh, treasurer, 847 North Eutaw street, and all subscriptions, either pledges or payments, may be sent to him. Make all checks payable to the Building Committee of the Medical and Chirurgical Faculty of Maryland.

PAID SUBSCRIPTIONS TO THE OSLER TESTIMONIAL FUND.

Atkinson, Dr. I. E., 609 Cathedral street, Baltimore	$100 00
Bernstein, Dr. Edward J., Kalamazoo, Mich	5 00
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Brush, Dr. Edward N., Towson, Md	150 00
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Buck, Dr. Jeffries, 2844 St. Paul street, Baltimore	10 00
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Carroll, Dr. James J., 330 North Charles street, Baltimore	20 00
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Crouch, Dr. J. F., 412 Cathedral street, Baltimore	20 00
Cullen, Dr. Thos. S., 3 West Preston street, Baltimore	100 00
Cushing, Dr. Ed. F., 967 Prospect avenue, Cleveland, Ohio	25 00
Cushing, Dr. Harvey W., 3 W. Franklin street, Baltimore	500 00

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

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COMPONENT SOCIETIES OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

LIST OF OFFICERS AND DATES OF MEETINGS.

NOTE.—*Secretaries are requested to advise the Secretary of the State Society promptly of the election of new officers in their respective Societies.*

ALLEGANY COUNTY MEDICAL SOCIETY.

President—S. A. BOUCHER, M.D., Barton, Md.
Secretary—WILLIAM R. FOARD, M.D., Cumberland, Md.
Treasurer—E. B. CLAYBROOK, M.D., Cumberland, Md.
First Tuesday in January, April, July and October.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY.

President—H. B. GANTT, M.D., Millersville, Md.
Secretary—L. B. HENKEL, JR., M.D., Annapolis, Md.
Treasurer—F. H. THOMPSON, M.D., Annapolis, Md.

BALTIMORE CITY MEDICAL SOCIETY.

President—A. C. HARRISON, M.D., 3 W. North Ave., Baltimore, Md.
Secretary—W. E. MAGRUDER, M.D., 922 Madison Ave., Baltimore, Md.
Treasurer—W. S. GARDNER, M.D., 6 W. Preston St., Baltimore, Md.
Meetings first Tuesday in April and December.

BALTIMORE COUNTY MEDICAL ASSOCIATION.

President—JAMES H. JARRETT, M.D., Towson, Md.
Secretary—R. C. MASSENBURG, M.D., Towson, Md.
Treasurer—B. WHITELEY, M.D., Catonsville, Md.
Towson, third Thursday, April to October, 2 P. M.; November to March, 1 P. M.

CALVERT COUNTY MEDICAL SOCIETY.

President—J. W. LEITCH, M.D., Huntingtown, Md.
Secretary—I. N. KING, M.D., Barstow, Md.
Treasurer—E. H. HINMAN, M.D., Lower Marlboro, Md.
Second Tuesday in April, August and December; annual meeting second Tuesday in December.

CAROLINE COUNTY MEDICAL SOCIETY.

President—THEO. SAULSBURY, M.D., Burrville, Md.
Secretary-Treasurer—J. R. DOWNS, M.D., Preston, Md.

CARROLL COUNTY MEDICAL SOCIETY.

President—JAMES H. BILLINGSLEA, M.D., Westminster, Md.
Secretary-Treasurer—CHARLES R. FOUTZ, M.D., Westminster, Md.
April, July and October; annual meeting in December.

CECIL COUNTY MEDICAL SOCIETY.

President—S. G. FISHER, M.D., Port Deposit, Md.
Secretary-Treasurer—HOWARD BRATTON, M.D., Elkton, Md.
Third Thursday (quarterly) at Elkton; annual meeting in April.

CHARLES COUNTY MEDICAL SOCIETY.

President—JOHN T. DIGGES, M.D., Port Tobacco, Md.
Secretary-Treasurer—THOMAS S. OWENS, M.D., La Plata, Md.
Meetings third Tuesday in May, August and November.

DORCHESTER COUNTY MEDICAL SOCIETY.

President—B. W. GOLDSBOROUGH, M.D., Cambridge, Md.
Secretary-Treasurer—W. H. HOUSTON, M.D., Fishing Creek, Md.
Meetings first Tuesday in May and December at Cambridge.

FREDERICK COUNTY MEDICAL SOCIETY.

President—J. W. DOWNEY, M.D., New Market, Md.
Secretary—IRA J. MCCURDY, M.D., Frederick, Md.
Treasurer—W. A. LONG, M.D., Frederick, Md.
January, April, August and November.

GARRETT COUNTY MEDICAL SOCIETY.

President—H. W. McCOMAS, M.D., Oakland, Md.
Secretary-Treasurer—J. G. SELBY, M.D., Eglon, W. Va.
Second Tuesday in May.

HARFORD COUNTY MEDICAL ASSOCIATION.

President—CHARLES BAGLEY, M.D., Bagley, Md.
Secretary-Treasurer—R. S. PAGE, M.D., Belair, Md.
Second Wednesday in January, March, May, July, September, November.

HOWARD COUNTY MEDICAL SOCIETY.

President—T. W. LINTHICUM, M.D., Savage, Md.
Secretary-Treasurer—L. GILLIS OWINGS, M.D., Ellicott City, Md.
First Tuesday in January, April, July and October.

KENT COUNTY MEDICAL SOCIETY.

President—THOMAS B. WILLSON, M.D., Edesville, Md.
Secretary—H. G. SIMPERS, M.D., Chestertown, Md.
Treasurer—G. I. BARWICK, M.D., Kennedyville, Md.

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President—E. ANDERSON, M.D., Rockville, Md.
Secretary-Treasurer—J. L. LEWIS, M.D., Bethesda, Md.
Third Tuesday in April and October.

PRINCE GEORGE'S COUNTY MEDICAL ASSOCIATION.

President—CHARLES A. FOX, M.D., Beltsville, Md.
Secretary—H. B. MCDONNELL, M.D., College Park, Md.
Treasurer—E. O. ETTIENNE, M.D., Berwyn, Md.
Second Saturday of every second month.

QUEEN ANNE'S COUNTY MEDICAL SOCIETY.

President—J. M. CORKRAN, M.D., Centreville, Md.
Secretary-Treasurer—E. F. SMITH, Centreville, Md.

ST. MARY'S COUNTY MEDICAL SOCIETY.

President—THOMAS LYNCH, M.D., Leonardtown, Md.
Secretary-Treasurer—J. O. KING, M.D., Oakville, Md.
Second Tuesday in May and October at Leonardtown, Md.

SOMERSET COUNTY MEDICAL SOCIETY.

President—C. W. WAINWRIGHT, M.D., Princess Anne, Md.
Secretary-Treasurer—RALPH L. HOYT, M.D., Oriole, Md.
First Tuesday in April at Crisfield; first Tuesday in November at Princess Anne.

TALBOT COUNTY MEDICAL SOCIETY.

President—E. R. TRIPPE, M.D., Easton, Md.
Secretary-Treasurer—A. B. HAYWARD, M.D., Easton, Md.
Annual meeting third Tuesday in November and semi-annual third Tuesday in May.

Washington County Medical Society.

President—Edwin M. Schindel, M.D., Hagerstown, Md.
Secretary—V. D. Miller, Jr., M.D., Hagerstown, Md.
Treasurer—H. K. Derr, M.D., Hagerstown, Md.
Second Thursday of February, May, September and November.

Wicomico County Medical Society.

President—F. M. Slemons, M.D., Salisbury, Md.
Secretary-Treasurer—E. W. Humphreys, M.D., Salisbury, Md.
Second Tuesday in May at Salisbury, Md.

Worcester County Medical Society.

President—J. S. Aydelotte, M.D., Snow Hill, Md.
Secretary—R. L. Hall, M.D., Pocomoke City, Md.
Treasurer—Paul Jones, M.D., Snow Hill, Md.
May and October.

MEETINGS OF COUNTY MEDICAL SOCIETIES.

ANNE ARUNDEL COUNTY.

The regular quarterly meeting of the Anne Arundel County Medical Society took place in the parlors of the Maryland Hotel, Annapolis, Md., Tuesday, April 16, 1907, at 11 A. M., with Dr. H. B. Gantt, President, in the chair. The principal topic was "Ideal Labor." Dr. Frank H. Thompson of Annapolis opened the discussion, in which he gave a lengthy talk of the different phases and conditions met with in obstetrical practice. Others taking part in the discussion were Doctors Lewis M. Allen of Baltimore, Gantt of Millersville, Winterson of Hanover, Welch, Henkel, Hopkins and Murphy of Annapolis.

Dr. L. M. Allen was the guest of the society, and his talk on sepsis and antiseptics in obstetrical work was very interesting.

Dr. Thomas H. Brayshaw of Glenburnie, Anne Arundel county, invited the society to meet at his beautiful home June 18, 1907, at which time he will entertain the society at a "social session." The President appointed the following committee to arrange a suitable program for this meeting: Doctors T. H. Brayshaw, J. S. Billingslea, L. B. Henkel and J. O. Purvis.

After the reading of numerous communications and passage thereon the society adjourned to meet again June 18, 1907.

The following were present: Doctors H. B. Gantt of Millersville, Lewis M. Allen of Baltimore, T. H. Brayshaw of Glenburnie, Billingslea of Armiger, Winterson of Hanover, Perrie of McKendree, Thompson, Worthington, Murphy, Hopkins, Hepburn, Welch, Purvis and L. B. Henkel of Annapolis.

CHARLES COUNTY.

THE annual meeting of the Charles County Medical Society was held at La Plata Tuesday, May 21, 1907, with 11 members present. The majority of the officers were re-elected. They are as follows: President, Dr. John T. Digges, Port Tobacco; secretary-treasurer, Dr. Thomas S. Owens, La Plata; censor, Dr. T. R. Gough, Newburg; delegate to State Association, Dr. L. C. Carrico; alternate, Dr. H. C. Chappelear, Hughesville.

The subject for general discussion was "Pneumonia and typhoid fever," which was participated in by a number of members and by Drs. Charles O'Donovan, F. J. Kirby and H. C. Irwin, who were present from Baltimore, and Dr. Lewellyn Eliot of Washington. Dr. Kirby also made an interesting address on the subject of malignant tumors.

The meeting was very successful, both socially and scientifically, and closed with a dinner at the hotel.

This society holds its meetings quarterly, and every eligible physician in Charles county except one is a member of the society, and they expect to include every one in a short while.

DORCHESTER COUNTY.

A WELL-ATTENDED meeting of the Dorchester County Medical Society was held in Cambridge May 14, 1907. The visiting physicians were entertained at luncheon by Dr. and Mrs. Guy Steele, after which Dr. Charles O'Donovan, president of the Medical and Chirurgical Faculty, delivered an address encouraging the physicians in their work of organization. Dr. H. Warren Buckler, chairman of the State Tuberculosis Sanitarium Commission, read a paper on the character of the cases desired for treatment, and especially urging the county men to send only incipient cases. Dr. Steele read a paper on "Common cases vs. theory in the treatment of pneumonia." Drs. Charles M. Hanby of Cambridge and C. F. Maguire of Hurlock were admitted to membership in the society.

WORCESTER COUNTY.

THE Worcester County Medical Society held a meeting at Snow Hill Tuesday, May 21, 1907, with 10 members present.

The question of life-insurance examinations for the old-line companies was taken up, and the resolutions adopted that no member of the society should make an examination for less than $5. They also resolved to send a copy of this resolution to every physician practicing in the county, whether a member of the society or not.

Dr. Thomas B. Futcher was present from Baltimore and talked on the subject of the "Etiology, diagnosis and treatment of various forms of arthritis."

Three new men were elected to membership.

MINUTES OF THE ANNUAL MEETING OF MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, APRIL 23-25, 1907.

HOUSE OF DELEGATES.

The 16th meeting of the House of Delegates was held in the hall of the Faculty April 23, 1907, at 2 P. M., Dr. Woods in the chair.

There were present Drs. A. H. Hawkins, W. H. Hopkins, H. L. Naylor, W. W. Goldsborough, H. Bratton, Guy Steele, F. B. Smith, W. F. Hines, R. Brooke, L. A. Griffith, J. A. Stevens, J. W. Humrichouse, L. W. Morris, Paul Jones, C. O'Donovan, J. H. Pleasants, J. W. Holland, J. M. H. Rowland, J. M. Craighill, J. E. Gichner, G. M. Linthicum, R. W. Johnson, T. H. Brayshaw, W. P. Miller, C. Birnie, S. T. Earle, Jr., T. A. Ashby, St. C. Spruill, C. M. Ellis, J. W. Williams, Hiram Woods, John Ruhräh, W. S. Gardner.

The minutes were read and approved.

The following reports were read and accepted by the House of Delegates.

Trustees report by Dr. C. M. Ellis, Chairman.

Report of Council by Dr. R. W. Johnson, Chairman.

Councilors' reports by Drs. Steele, Gardner, Brayshaw, Birnie, Miller and Jones. Dr. Hines made the report for Dr. Earle, who was absent.

Report of Relief Fund Committee by Dr. Cordell, Chairman.

The President ruled that the funds of the Committee should be held by the Treasurer of the Faculty.

Dr. Ashby offered an objection, which was withdrawn.

Dr. Cordell expressed his willingness to turn over the funds of the Committee.

The Memoir Committee's report was read by Dr. J. T. Smith, Chairman.

Report of the Library Committee by Dr. J. W. Williams, Chairman.

Report of the State Board of Medical Examiners by Dr. J. McP. Scott, Secretary.

It was moved by Dr. Earle that the report of the State Board of Medical Examiners, with recommendations made by the Board, be referred to the Committee on Legislation, which Committee is to report at the semi-annual meeting. This motion was carried.

Report of the Secretary by Dr. John Ruhräh.

Report of the Treasurer by Dr. Gardner.

The Committee on Midwifery Law reported through their Chairman, Dr. G. Steele, who presented a majority and minority report, same to be taken up at 9.45 A. M. Wednesday on special order.

Consideration of Dr. Thayer's and Dr. Warfield's reports on special order for 9 A. M. Wednesday.

The House adjourned.

The 17th meeting of the House of Delegates was held in the Donovan Room, McCoy Hall, Johns Hopkins University, April 24, 1907, at 9 A. M., Dr. Woods presiding.

There were present Drs. L. A. Griffith, S. J. Fort, J. M. H. Rowland, T. M. Chaney, C. Birnie, R. W. Johnson, W. S. Gardner, G. M. Linthicum, R. Brooke, Paul Jones, T. H. Brayshaw, J. W. Humrichouse, A. H. Hawkins, J. A. Stevens, W. W. Goldsborough, W. F. Hines, C. O'Donovan, H. Bratton, L. W. Morris, J. W. Williams, C. M. Ellis, J. H. Pleasants, Hiram Woods, John Ruhräh.

The minutes were read and approved.

The report of the Committee on Dispensary Abuse was first considered.

On motion of Dr. Ellis this subject was referred from the Faculty to the Baltimore City Medical Society to continue the work.

Report of the Committee on Lay Press was discussed by Drs. Ellis, Chaney and Birnie.

On motion of Dr. Chaney the Committee was ordered to continue, all appointments to be made by the President.

Dr. Ellis moved that a committee of five be appointed by the President to take up the subject of instruction of the public.

The motion was carried.

Dr. O'Donovan moved that any committee suggested in the general meeting to take up the question of the formation of a branch of the Society for Sanitary and Moral Prophylaxis be reported to the Council with power to make appointments. Carried.

The following amendment to the Constitution, introduced at the last annual meeting, was carried: Article 6. "No Councilor shall be eligible as a delegate of a component society."

Dr. Birnie moved that the business arrangements between the Faculty and the MARYLAND MEDICAL JOURNAL be left to the Council with power to act. Motion carried.

Dr. Pleasants introduced a resolution concerning the examination of the eyes and ears of school children, and after considerable discussion by Drs. Woods, Linthicum, Humrichouse and Hines the following resolution was adopted:

"Whereas, The value of perfect sight and hearing is not fully appreciated by educators, and neglect of the delicate organs of vision and hearing often leads to disease of these structures; therefore be it

"*Resolved,* That it is the sense of the Medical and Chirurgical Faculty of Maryland that measures be taken by boards of health, boards of education and school authorities, and, where possible, legislation be secured, looking to the examination of the eyes and ears of all school children, that disease in its incipiency may be discovered and corrected."

Dr. Steele moved the adoption of the minority report of the Committee on Midwifery Law. Seconded by Dr. Stevens.

After considerable discussion and deliberation of several amendments the following amendment of Dr. Johnson was adopted:

"*Resolved,* That the reports of the Midwifery Committee be referred to the Legislative Committee with instructions from the House of Delegates that a law regulating the practice of midwifery be presented to the semi-annual meeting."

Dr. Linthicum moved that the minority report be adopted as representing the sentiment of the House of Delegates. Seconded by Dr. Gardner. The motion was lost.

Dr. Linthicum presented the following amendment to the Constitution: Article 5. "No member of the State Board of Medical Examiners shall be a member of the House of Delegates, except the Secretary, who shall be a member *ex-officio*.

Dr. Steele offered the following amendment to the Constitution: Article 5, add the words "and the delegates to the House of Delegates of the American Medical Association."

Both of these amendments were laid over according to the Constitution.

The House of Delegates then adjourned until 9 o'clock Thursday.

The 18th meeting of the House of Delegates was held in the Donovan Room, McCoy Hall, Johns Hopkins University, April 25, at 9 A. M., Dr. Woods in the chair.

There were present Drs. A. H. Hawkins, W. H. Hopkins, H. L. Naylor, T. M. Chaney, Guy Steele, F. B. Smith, S. J. Fort, W. F. Hines, R. Brooke, L. A. Griffith, N. Dudley, L. W. Morris, Paul Jones, J. H. Pleasants, J. M. H. Rowland, J. E. Gichner, G. M. Linthicum, R. W. Johnson, T. H. Brayshaw, T. A. Ashby, Hiram Woods, John Ruhräh, W. S. Gardner, C. M. Ellis.

The minutes were read and approved.

Dr. Ellis moved that the Council take up the matter of the portrait of Dr. Archer and secure $100 for the painting and framing of said portrait.

After considerable discussion it was passed.

Dr. Fort offered the following amendment to the Constitution: Article 9, Section 3. "The officers of this Faculty shall be nominated by the House of Delegates at the second meeting of that body, and shall be elected on the morning of the annual session."

Dr. Gardner moved that the House of Delegates nominate five names for members of the State Board of Medical Examiners, to be referred to the general meeting.

Dr. Ashby offered an amendment making the number six.

After considerable discussion by Drs. Ashby, Steele, Gardner, Dudley, Woods, O'Donovan, Chaney, Hawkins and Ruhräh, the motion was carried.

The following nominations were made: Drs. W. W. Goldsborough, L. A. Griffith, J. A. Stevens, W. R. Eareckson, H. B. Thomas, J. M. Corkran, W. P. Miller, A. H. Hawkins.

The following names were offered: Drs. L. A. Griffith, J. A. Stevens, W. R. Eareckson, H. B. Thomas, H. P. Miller and A. H. Hawkins.

The officers were then elected as follows:

President—Dr. Charles O'Donovan.

Vice-Presidents—Drs. R. Brooke, H. L. P. Naylor, G. Dobbin.

Secretary—Dr. John Ruhräh.

Treasurer—Dr. W. S. Gardner.

Trustees—Dr. C. M. Ellis, and Dr. G. L. Taneyhill to fill unexpired term of Dr. I. E. Atkinson.

Councilors—Drs. St. C. Spruill, H. Bratton, L. F. Barker and H. Woods.

Delegate to American Medical Association—Dr. H. Friedenwald. Alternate—Dr. G. M. Linthicum.

Committee on Public Policy and Legislation—Drs. J. D. Blake, H. Harlan and W. W. Goldsborough.

Committee on Scientific Work and Arrangements—Drs. G. M. Linthicum and J. A. Chatard; *ex-officio,* Dr. J. Ruhräh.

Library Committee—Drs. J. W. Williams, H. B. Jacobs, M. Sherwood, T. B. Futcher, H. Adler.

The following committees were appointed by the President:

Memoir Committee—Drs. J. T. Smith, S. R. Waters, Jacob H. Hartman, L. C. Carrico, A. T. Gundry.

Committee for Fund for Relief of Widows and Orphans of Deceased Members—Drs. E. F. Cordell, J. C. McGill, G. T. Atkinson, S. D. Wilson, H. J. Berkley.

Committee to Confer With Lay Press—Drs. R. B. Warfield, L. M. Allen, Marshall Price, J. J. Carroll, C. H. Jones.

Committee on Public Instruction—Drs. Gordon Wilson, J. W. Lord, H. W. Buckler, F. Pollack, F. B. Smith.

Auxiliary Congressional and Legislative Committee of the American Medical Association—Dr. William Caspari.

Committee on Medical Education—Drs. W. H. Howell, St. C. Spruill, D. Streett, C. F. Bevan.

Committee on Sanitary and Moral Prophylaxis—Drs. D. R. Hooker, O. E. Janney, Lilian Welsh, J. M. Hundley, A. H. Whitridge.

Delegates to the Delaware State Medical Association—Drs. A. G. Barrett, J. D. Fiske and A. Lee Ellis.

Delegates to the Pennsylvania State Medical Association—Drs. James Bordley, Jr., and C. N. Gabriel.

Delegates to the Virginia State Medical Association—Drs. G. C. Dohme and E. B. Fenby.

Delegates to the West Virginia State Medical Association—Drs. J. S. Bishop and C. C. Conser.

The House of Delegates adjourned.

At the general meeting Drs. L. A. Griffith and J. A. Stevens were re-elected members of the State Board of Medical Examiners.

MINUTES OF THE GENERAL SESSION.

THE 109th annual meeting of the Medical and Chirurgical Faculty of Maryland was held at Baltimore, April 23-25, 1907.

The opening session was held at McCoy Hall, Johns Hopkins University, Tuesday evening, April 23, at 8.30 o'clock, the President, Dr. Woods, in the chair.

A certificate presented by Dr. Mary E. Gaston, delegate from the New Jersey State Medical Society, was read and accepted.

President's Address—"The Medical and Chirurgical Faculty: Its debt to itself and the public."—Dr. Hiram Woods.

Some results of the work by the State Board of Medical Examiners.—Dr. J. McP. Scott, Secretary.

Report of Committee to Confer with Lay Press.—Dr. R. B. Warfield, Chairman.

Report of Committee on Dispensary Abuse.—Dr. W. S. Thayer, Chairman.

Presentation of portraits.—Presentation address.—Dr. S. C. Chew.

"I have been requested by Mrs. Mary F. Birch, a daughter of the late Dr. John Hawkins Patterson, to present to the Medical and Chirurgical Faculty of Maryland, in her name, a portrait of her honored father which was painted by the well-known artist, J. Dabour. It is the cherished and dutiful desire of this lady that this likeness of her father shall be given a place in our hall along with other portraits of members of the medical profession who were also members of this Faculty. I suppose that this request has been made of me for the reason that I was perhaps for a longer time contemporaneous with Dr. Patterson in active practice than any other present member of the Faculty. This might seem to indicate a wide gap between him and those coeval with him, on the one hand, and the present generation of physicians, on the other, but it is to be considered that very many of his immediate associates preceded or soon followed him in their exit from this world. In fact, he had begun the practice of medicine before my birth.

Dr. Patterson was born in Baltimore on August 10, 1816, his father, William Presbury Patterson, having been, I think, a native of Scotland. He studied medicine in the office of Dr. Ashton Alexander, who was one of the founders of this Faculty and also for 13 years Provost of the University of Maryland, in the medical school of which Dr. Patterson was graduated in 1837, and on the death of his preceptor he fell heir, I have been told, to a large amount of his practice. He was the friend as well as the physician of many prominent families in this city, among whom he practiced for more than half a century; but he found time also for unremunerated work among the poor. For more than 30 years he was physician to St. Paul's Orphanage, where he is still held in grateful remembrance. He has been described by one who knew him well as "genial and cordial in manner, unremitting in the care of his patients, and commanding the love and respect of his brethren in the profession."

He died May 25, 1893.

I have been requested also by the president of the Faculty to state further that another portrait, that of the late Dr. Charles Hyland Jones, has recently been presented by his family to the Faculty, accompanied with a number of Dr. Jones' books, which are given as a contribution to our library. Dr. Jones was known to many here present as a most upright and honorable

member of our profession and of this Faculty, faithful to the duties of his calling and in every relation in life.

These portraits are now committed in the names of their respective donors to the keeping of the Medical and Chirurgical Faculty."

Dr. C. M. Ellis reported as Chairman of the Committee appointed to submit the name of one of the founders of the Faculty of whom a portrait should be made for presentation to Governor Warfield, same to be hung in the State House.

The name placed before the general session for consideration was that of Dr. John Archer, which was chosen unanimously.

Dr. W. H. Welch moved that recommendation be made to the House of Delegates for the appointment of a Committee on Public Instruction. Carried.

Wednesday Morning Session, April 24, 1907, Faculty Hall, 10.30 o'clock.

In the absence of the President, Dr. Woods, the Vice-President, Dr. W. T. Watson, took the chair.

The following papers were read:

The logical basis of neurasthenia.—Dr. A. K. Bond.

The indications for surgical intervention in the treatment of chronic suppurative otitis media.—Dr. H. O. Reik.

Discussion by Drs. Carroll, Watson, Woods and Reik.

A case of gangrene of foot and leg following appendicitis.—Dr. R. Winslow.

The present status of vaginal Caesarean section.—Dr. L. M. Allen.

Tonsillar infections.—Dr. F. D. Sanger.

Discussion by Drs. R. Winslow, Kintzing, Atkinson, Watson and J. T. Smith.

Erysipelatous cellulitis of eyelid and the effect of antistreptococcus serum.—Dr. H. Friedenwald.

Discussion by Dr. Stokes.

Patent and proprietary medicines.—Dr. L. B. Henkel, Jr.

Wednesday Afternoon Session, April 24, Faculty Hall, 4.30 o'clock.

Dr. Woods in the chair.

The papers read were:

The present status of the anti-tuberculosis movement in Maryland.—Dr. J. S. Fulton.

A description of the State Hospital for Consumptives with an outline of its proposed work.—Dr. H. W. Buckler.

Discussion by Drs. Jacobs, Atkinson, Futcher, Reed, Harris, Bradley, Winsey, Fitzhugh, Guy Steele and Fulton.

The medical inspection of public schools.—Dr. J. H. Pleasants.

A partial analysis of cases of typhoid fever in 1906. Lantern slides.—Dr. C. H. Jones.

Wednesday Evening Session, April 24, McCoy Hall, Johns Hopkins University, 8.30 o'clock. Dr. Woods in the chair.

Annual oration—"The campaign against the domination of therapeutics by commercialism."—Dr. Geo. H. Simmons, Chicago.

Dr. Welch moved that a vote of thanks be offered Dr. Simmons for his most admirable address. Seconded by Dr. Birnie and carried.

A special meeting of the Faculty was held immediately after Dr. Simmons' oration. The object of the meeting was to set before the membership some facts bearing on the need of a new Faculty home and means of obtaining it. The subject was presented by Dr. E. N. Brush, Chairman of Building Committee, and Dr. R. W. Johnson, Chairman of the Council.

A short discussion followed by Drs. Blake and Bond.

Thursday Morning Session, April 25, Faculty Hall, 11 o'clock.

Vice-President Dr. Watson in the chair.

The program was carried out as follows:

Election of two members for the State Board of Medical Examiners.

The names submitted from the House of Delegates were Drs. L. A. Griffith, J. A. Stevens, W. R. Eareckson, H. B. Thomas, W. P. Miller and A. H. Hawkins.

Drs. L. A. Griffith and J. A. Stevens were re-elected.

Scientific session continued.

The value of laboratory methods in the early diagnosis of gastric carcinome. Report of 27 cases.—Dr. C. U. Smith.

Discussion by Drs. Branham, Rosenthal and C. U. Smith.

Some observations on the absence or marked diminution of HCl of the gastric contents in cancer of organs other than the stomach.—Dr. J. Friedenwald, Dr. L. J. Rosenthal.

Discussion by Drs. C. U. Smith and Rosenthal.

a. A preliminary report of an epidemic catarrhal affection in Baltimore. —Dr. H. G. Beck.

b. Bacteriological study.—Dr. W. R. Stokes.

Tumors of aberrant thyroid tissue.—Dr. A. McGlannan.

The calibration of pistol bullets.—Dr. S. J. Fort.

Prescription clinic.—Henry P. Hynson. (To be read at another meeting.)

Diagnosis and treatment of calculus of lower end of ureter.—Dr. H. H. Young.

Discussion by Drs. Blake and Watson.

Thursday Afternoon Session, April 25, McCoy Hall, Johns Hopkins University, 3.45 o'clock.

Joint meeting with the Maryland State Conference of Charities and the Maryland State Federation of Women's Clubs.

The prophylaxis of social diseases.—Dr. Prince A. Morrow, New York.

The prophylaxis of social disease in the home.—Dr. Lilian Welsh.

Duty of the organized medical profession in fighting the social evil.—Dr. C. P. Emerson.

Short talks were made by Dr. Howard A. Kelly and Assistant District Attorney O'Dunne.

Statistics were given by Dr. Flora Pollack.

A motion was offered by Dr. Fulton that a society be started in Baltimore as a branch of the Society of Sanitary and Moral Prophylaxis. Seconded by Dr. Janney.

Mr. Glenn moved that a vote of thanks be tendered Dr. Morrow for his interesting paper. Seconded and carried.

The meeting adjourned.

A very enjoyable and successful banquet was held Thursday evening, April 25, at 8 o'clock, in the Hall of the Faculty, over 100 physicians being present.

The success of the banquet was in great part due to the indefatigable efforts of the members of the Committee of Arrangements, Drs. A. P. Herring, Chairman, and G. M. Linthicum, who were ably seconded by the members of the Reception Committee, Drs. Wm. Tarun, E. Novak, J. A. Chatard, H. G. Beck, William Caspari, S. Cone, H. Lee Smith, M. Lazenby, A. Keidel and J. T. O'Mara.

Books Received.

Receipt is acknowledged of the following books:

Abdominal and Pelvic Brain With Automatic Visceral Ganglia. By Byron Robinson, B.S., M.D. Publisher, Frank S. Betz.

A Manual of Obstetrics. By A. F. A. King, A.M., M.D., LL.D. Tenth edition, revised and enlarged. Publishers, Lea Bros. & Co. 1907.

International Clinics. By W. T. Longcope, M.D. Vol. 1, seventeenth series. Publishers, J. B. Lippincott Company. 1907.

Physical Diagnosis. By Howard S. Anders, A.M., M.D. Publishers, D. Appleton & Co. 1907.

Fifty-eighth Annual Report of the Central Indiana Hospital for Insane for Year Ending October 31, 1906. Indianapolis, Ind.: W. B. Burford. 1906.

Transactions of the Thirty-seventh Annual Session of the Medical Society of Virginia, Held in Charlottesville, Va., October 9-11, 1906. Williams Printing Co. 1906.

Metabolism and Practical Medicine. By Carl von Noorden. Vol. 1, The Physiology of Metabolism; Vol. 2, The Pathology of Metabolism. Publishers, W. T. Keener & Co. 1907.

A Practitioner's Handbook of Materia Medica and Therapeutics. By Thos. S. Blair, M.D. Publisher, The Medical Council, Philadelphia, Pa. $2 net.

The Miracle Worker. By Gerald Maxwell. Publishers, John W. Luce & Co. 1907. Price, $1.50.

Wellcome's Photographic Exposure Record and Diary. Publishers, Burroughs, Wellcome & Co. 1907. Price, 50 cents.

A Treatise on the Principles and Practice of Medicine. By Arthur R. Edwards, A.M., M.D. Publishers, Lea Bros. & Co.

THE NEW ANTI-NARCOTIC LAW FROM THE STANDPOINT OF THE PHYSICIAN.

By W. R. Dunton, Jr., M.D.

REMARKS BEFORE THE BALTIMORE BRANCH OF THE AMERICAN PHARMACEUTICAL SOCIETY

I THINK the universal sentiment among physicians regarding the passage of the new anti-narcotic law is one of congratulation that conditions are so much improved and that persons cannot procure narcotics so easily. Those who deal with any class of habitues know how lacking in will power they are, and how they have to be helped most vigorously to overcome the grip which their drug habit has upon them. Even with such help it is not unusual for such cases to relapse the moment they leave off hospital treatment, and on the way from the hospital to their home they will stop at a drug store and procure a supply of the drug from the use of which they have spent months in trying to be relieved. Further, every physician who treats a patient outside of a hospital has had the annoyance of having had the patient to continue indefinitely to take a medicine which has been prescribed, and to state that it is done by the physician's orders, even though the physician has not seen the patient for months. To those who understand the effects of narcotic drugs (and the effects of opium are apparently well understood by the laity) such a course is bound to cause the physician loss of reputation among well-thinking persons, and, therefore, the passage of such a law is for the protection of his reputation. These same objections apply less strongly to the renewal of all prescriptions, and I wish that the law had been made to include the renewal of all prescriptions.

Occasionally it will undoubtedly cause us some annoyance and a slight loss of time to see the patient, ascertain whether the prescription should be renewed and to renew the prescription, but we will be able to treat them more intelligently by seeing them more frequently. While the criticism will perhaps be made that such a law secures more consultations to the physicians, and is a method of advancing commercialism in medicine, this can be easily overcome by the physician making a charge for such consultation different from that for the first visit; but, after all, it is hardly worth while for us to pay much attention to a criticism of this sort, because it will proceed from those who do not understand the situation and whose criticism cannot do us serious harm.

I regret exceedingly that laudanum and paregoric, and Dover's powder, liniments and ointments, if labelled "for external use only," and preparations sold in good faith for diarrhea and colic, as well as certain proprietory medicines, should be exempt from this law, although apparently the quantities of opium which the latter contain is so small that little harm can occur from their use. With laudanum and paregoric, however, there is no guarantee that the purchaser intends to use them properly. I can recall one case in which it was necessary to secure six ounces of laudanum or an equal quantity of paregoric at least twice a week. The person's physical

signs, however, showed plainly that it was used in a way that had not been intended by the seller.

We must be satisfied, however, with the substantial progress that has been made, and which I hope in time will lead to a further modification, so that no prescriptions shall be renewed without the order of the physician. In this way I feel that the community will learn that physicians take an interest in their cases; that they want to carry them through the illness and secure recovery; that they are not merely interested in payment of fees for visits.

Another side of the question should be mentioned, and that is the administration of hypodermics of morphia or other alkaloids by the nurse. It is the custom of some physicians I know to require their nurses to carry with them a pocket case containing various hypodermic tablets in order that they may be prepared to meet emergencies and be ready to administer the hypordermic which the physician may order. Of course, these vials cannot be refilled without the physician's prescription, so that the nurse is not liable to indulge in indiscriminate medication, even if she be so disposed. At the same time, I feel that it is shifting a responsibility from physician to nurse and that it is better for the physician to supply a nurse with tablets at the time of his visit from his own pocket case when they are likely to be required for emergency use, or if their use is to be continued regularly over a long duration, as, for example, in relieving the pains in a case of carcinoma, the supply can be obtained from the drug store, just as any other bottle of medicine can upon the physician's prescription.

With the passage of the pure-food bill and the present anti-narcotic law I feel that a distinct advance has been made in the treatment of our patients, and I trust that benefit will accrue to both the community and to physicians through their operation.

Society Reports.

THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY.

MEETING OF DECEMBER 17—CONCLUDED.

Case 3. Man, 41 years old, with a history suggestive of pulmonary tuberculosis. In 1905 he had what was supposed to be a cold abscess over his chest. He was admitted to the Hospital in 1905, but had not been well since 1903. His left pleural cavity was filled with fluid, his liver and spleen were enlarged, and the lymph glands of the neck were enlarged. One of these glands was removed for diagnosis and showed typical Hogkins Disease. Tubercle bacilli were also found in the sputum. It is very common to find tuberculosis associated with Hogkins Disease. The patient was admitted again in October, 1906, with the same complaint. There was a right pleural effusion, some ascites and edema of both legs, penis, scrotum, back and abdomen. The edema was less in the left than in the right lower extremity. Fluoroscopic examination on his previous admission had shown masses in his mediastinum. His urine was smoky, contained 15 to 22 grams of albumin to the liter, had a specific gravity of 1012 to 1019, and it contained a few red-blood corpuscles and a few small mononuclear leucocytes. No fat droplets were found, no fatty epithelium, no sugar. The pleural fluid resembled a transudate in that it had a specific gravity of only 1017 to 1019. Physical examination showed marked edema of the legs and thighs, some venous ectasis, more marked on the right side, great edema of the lower part of the trunk. The enlargement of the abdomen was due more to the edema of the wall than to the ascites. There was no edema of the upper trunk and arms, which were emaciated. There was marked dilation of the thoracoepigastric veins. This is masked by the edema now. There is no dilation of the para-umbilical veins, and also no caput medusa. The condition is clear. It is not a general venous stasis with general anasarca, for there is no evidence of interference of the superior vena cava. It is the domain of reception of the inferior vena cava that is affected. It is not obstruction of the thoracic duct, for there is nearly always ascites with this condition. There is also usually a double hydrothorax with a milky fluid, and rarely edema of the trunk. Again, no free fat or fatty cells were found. The obstruction is evidently of the inferior vena cava. The dilation of the lateral veins of the trunk are right for this. In portal obstruction the veins about the umbilicus are dilated. Unilateral edema is often noted in inferior vena cava obstruction, because the collateral circulation develops more easily on one side than on the other. The condition may reverse later. An interesting question is whether the vena azygos is involved. One often sees a recurring hydrothorax on the right side from obstruction of the right vena azygos. The condition in this case is probably not due to obstruction of the inferior vena cava by a mediastinal tumor. It is more likely thrombosis of the inferior vena cava, and it is not impos-

sible that obstruction of the vena azygos has lead to thrombosis, which has extended down to the vena cava. Cicatrical bands may have formed in the thorax, constricting the inferior cava. But why not more symptoms of portal obstruction, and why not hematuria? Portal circulation may be partly obstructed, and collateral circulation of the renal veins may enable the kidneys to take care of themselves.

Dr. Thayer suggests that the inferior vena cava inferior may be obstructed in passing through the liver, and adds that recurring right hydrothorax is common in heart disease due to pressure on the azygos.

Dr. McCallum—Several cases of intra-thoracic goitre have been reported, but it is hardly possible here in so young a child. Lympho-sarcoma are common in small children. The relation between tuberculosis and Hodgkins Disease has been definitely proven, Dr. Dorothy Reed having shown them to be separate pathological conditions. Tuberculosis and Hodgkins may occur at the same time, as has been shown by autopsy. Dr. McCallum is inclined to agree with the suggestion of Dr. Thayer's concerning the obstruction of the inferior vena cava in the liver, at the same time admitting that thrombosis may be the cause of the obstruction.

Exhibition of Cases—Dr. Watts. Case 1. This patient, who is 24 years old, was admitted on August 7, 1906, with the following history: First attack of abdominal pain three years ago. Second present attack of two weeks' duration, with symptoms of incomplete intestinal obstruction; abdominal cramps, slight diarrhea with bloody stools, vomited once before admission and several times after admission. Examination—Abdomen fairly flat, distended loops of bowel and marked peristalsis seen, ladder pattern. On the right side of the abdomen a large, soft mass could be felt in the region of the ascending colon. There was no general glandular enlargement. Pulse 21 to the quarter minute and of good quality, temperature 99.4, leucocytes 15,600. At operation the obstruction was found to be due to an intussusception at the ilio-cecal valve. The length of the intussusception was 25 centimeters. The intestine above the obstruction was much distended and its walls hypertrophed. The intussusception was reduced without great difficulty by Senn's method, few adhesions and no gangrene of the bowel being present. Examination of the intestine after reduction showed the presence of three rather pedunculated intra-intestinal growths. These varied from three to six centimeters in diameter, were rather spherical, smooth, fairly soft. Two were located in the small intestine, one 25 centimeters above the ilio-cecal valve, the other and smaller one 20 centimeters higher up in the intestine. The lower, larger one occupied the apex of the intussusception, and was doubtless the cause of the intussusception. Traction upon the growth by the peristalsis had caused an umbilication of the intestine opposite to its attachment, which was near the mesentery. The third tumor, very similar to the last one, was situated in the sigmoid colon. On account of the distended condition of the intestine a resection was deemed inadvisable, and the abdomen was closed. As might have been expected, the intussusception reappeared after a few days. The abdominal wound was reopened, and practically the same condition of affairs was found as at the first operation. The intussusception was reduced with much more difficulty on account of the edema of the intestine, considerable force being necessary. About 17 inches of small intes-

tine, containing two of the tumors, was excised, and the ends of the intestine united by a lateral anastomosis. The patient did well after the operation, but continued to have cramps, due to the obstruction produced by the tumor in the sigmoid. On October 9 an incision was made in the left side of the abdomen. The growth in the sigmoid was located and excised along with five inches of colon. The intestine was joined by a lateral anastomosis. Examination of the small intestine showed the presence of another tumor about three to four centimeters in diameter, which had escaped notice at the previous operations. This tumor, which was situated about 40 centimeters above the other small intestinal anastomosis, tended to produce another intussusception, so a lateral anastomosis was done around it. It was thought that the patient's condition hardly justified another resection. The patient has done excellently since this operation, has gained in weight, and is now ready to have another operation.

Pathological Report—The tumors are spherical, more or less pedunculated affairs, measuring from three to five centimeters in diameter. The surface of the smaller tumors is fairly smooth, while that of the larger ones is rough, papillomatous. The small tumors show no tendency to invade the musculature of the intestine. The larger tumor of the ileum, however, has apparently invaded the muscles to some extent. The large papilloma of the sigmoid shows little if any such tendency. Microscopic examination of the larger tumor mentioned above shows a beautiful papillomatous structure, with definite down-growth of the glands into the muscle. These glands contain a great deal of colloid material. There is no tendency of the individual cells to invade the lymph spaces, and little if any destruction of tissue. Sections of the smaller growths show no signs of malignancy. A small gland removed from the mesentery of the sigmoid opposite the growth shows no metastasis.

Case 2. This patient, who is 52 years old, entered the Hospital on April 8, 1906, with the following history: She had had an umbilical hernia for 10 years. The hernia had frequently caused a great deal of pain and inconvenience, apparently never being completely reducible. For a month previous to admission she had been incapacitated for work, had been in bed three weeks, being able to take very little food and vomiting almost daily. Four days before admission the vomitus became dark, foul and very frequent, and the patient had frequent, very severe abdominal cramps. Bowels moved slightly every day. On admission patient was found to be in very poor shape; pulse of poor quality, 23 to the quarter; leucocytes 31,800, temperature 100. There was a strangulated umbilical hernia 18 centimeters in diameter. The skin over it was reddened and fluctuation was present. The abdomen was not greatly distended and no loops of bowel were visible and no evidence of preistalsis. The patient was operated upon immediately with cocaine anesthesia, and the sac was found to contain a considerable amount of dark, foul fluid, gangrenous omentum and a gangrenous loop of small bowel. The contents of the sac were flushed with bichloride, a portion of the gangrenous omentum and small bowel excised, and the constriction liberated. Considering the dirty contents of the sac and the poor condition of the patient, it was not thought advisable to attempt an intestinal anastomosis and reduction of the hernial contents. Accordingly, rubber tubes were sutured into either end of the loops of

bowel and the wound packed with gauze. The patient did very well after the operation, considering the amount of nourishment lost through the intestinal fistula. Digital examination some days after the operation showed that the ends of bowel lay side by side, so that on May 1, 12 days after the operation, a curved stomach clamp armed with rubber was applied, a blade being placed in each end of the intestine after the manner of Duyputren. Each day the compression of the clamp was increased somewhat. The septum sloughed and the clamp came away on the 10th day, an anastomosis being thus produced. On May 12, with cocaine anesthesia, the ends of the intestine were inverted and closed. The patient made an excellent recovery, never having had to take a general anesthetic.

Case 3. This patient was admitted to the Hospital in April, 1904, with symptoms indicating a stricture of the esophagus. In the previous September, that is, about seven or eight months before his admission, he had a severe attack of typhoid fever, the temperature being at times 105 or more. He had several hemorrhages from the bowels during the illness, but none from the esophagus. The first trouble in swallowing was noticed two months after the onset of the illness, the patient having difficulty in swallowing beefsteak. From this time difficulty increased until only liquids could be swallowed. When admitted to the Hospital he could swallow liquids only with great difficulty, the fluids often regurgitating. He weighed only 89 pounds, whereas his normal weight was 125 pounds. On examination a light stricture of the esophagus was encountered about 28 centimeters from the teeth. This stricture admitted only a very small whalebone bougie, the largest that could be passed being only three milimeters in diameter. At first the stricture would admit none of the olive-tipped bougies at hand. The introduction of numerous filiform bougies, sometimes as many as eight or ten at a time, was of the greatest service in dilating the stricture. After the stricture had been stretched somewhat by this means the dilation progressed rapidly. He can now pass a sound as large as one's finger and eat anything he wishes. Typhoid lesions of the esophagus in general and typhoidal strictures in particular are rather rare occurrences. There have been only two cases of typhoidal stricture of the esophagus in the Hospital since it opened. One of these was reported in the Hospital Reports for 1900 by Mitchell. This is the second case. Other cases have been reported by Packard, Summers, Roberts and others.

Case 4. This patient was not shown. His age is 62 years. He was admitted to the Hospital on September 10, 1906, with the following history: About a year before admission he had noticed a small swelling "like a waxing kernel" below the angle of the jaw. Before this nodule was noticed the patient had been treated for "neuralgia of the neck" for several weeks. The tumor gradually increased in size up to the time of admission, and the pain in the tumor became severe, constant, and radiated to the left ear and to the head posterior to the ear, doubtless from involvement of the auricular nerves. Examination on admission showed the presence of an oval tumor about 5.5 by 7.5 centimeters in diameter below the left angle of the jaw and beneath the anterior edge of the left sterno-cleido-mastoid muscle. The tumor was slightly lobulated, hard, slightly elastic; elasticity more marked than is usual with carcinoma. It was freely movable on the underlying tissue. The cartoid vessels lay deeply beneath it. A small,

soft gland was felt in the submaxillary triangle, but none along the jugular vein beneath the sterno-cleido-mastoid muscle. No primary carcinoma was anywhere present, so a diagnosis was made of mixed tumor of the parotid gland. At the operation, on September 12, 1906, an incision was made along the anterior border of the sterno-cleido-mastoid muscle, exposing the tumor, which was found to be somewhat encapsulated. The sterno-cleido-mastoid was divided near its sternal attachment and the internal jugular vein exposed. The vein was as large as one's thumb, and in its lumen was seen a fingerlike process, evidently an intra-vascular growth of the tumor, surrounded by blood. This growth, which extended down the vein almost to the clavicle, was stripped up inside of the vein and the vein divided after being doubly ligated. On further examination the growth was found to have extended into most of the important branches of the jugular vein, the superior thyroid, facial and lingual branches. These branches were divided beyond the intra-vascular growth and the tumor turned outward. The tumor was quite intimately associated with both the internal and external cartoid arteries, suggesting a cartoid-gland tumor, but it could be stripped away from the internal cartoid, the external cartoid being excised with the tumor. The internal jugular vein distal to the growth was quite small. It was likewise ligated and divided here. The tumor was then removed, along with a portion of the sterno-cleido-mastoid muscle, portions of the spinal accessory and hypoglossal nerves, and the contents of the submaxillary triangle, which consisted of the submaxillary salivary gland, and a few small lymph glands. The tumor, while near both the submaxillary salivary and parotid glands, did not seem to be very intimately associated with either one. It was perhaps more closely attached to the parotid than to the submaxillary salivary gland. The patient did well after the operation and left the Hospital in two weeks.

Pathological Report.—Cross description—Shape is roughly spherical, about the size of a hen's egg. Presents definite broad nodules on its surface and possesses a definite capsule. Measures roughly 7x6x5 centimeters. Consistency varies somewhat; at upper pole, hard, boardlike and very slightly elastic; toward the other end, more elastic and less resistant, and resembles very much the consistency of a normal lymph gland. The nodules are firm, elastic and resistant. There seems to be no invasion of the muscle or of the jugular vein, except at the part where the nodules project into the lumen, where there seems to be invasion of the wall of the vein. There are apparently no such structures in any of the arteries. On section the tumor cuts with resistance at its hard, firm pole, in some places being almost cartilaginous, while at the other pole the knife passes with ease through a homogeneous, elastic, pinkish tissue. Microscope description—The picture varies in the different parts of the tumor. The middle part of the main tumor shows a dense, scirrhus arrangement of masses of spindle and round cells in a firm, thick, fibrous framework. The spindle cells and the round cells are for the most part grouped separately, though there are a few spindle cells in the round cell masses. The spindle cells form elongated, irregular-shaped or stellate-like groups with ragged and pointed borders. They roughly resemble scirrhus carcinomatous masses, but the individual cells are everywhere closely related to the surrounding fibrous tissue and seem to fuse in many places directly with

fibrous cells. Beside the characteristic spindle cell with its fusiform-shaped nucleus there are large endothelial, cylindrical and cuboidal cells with large oval vesicular nuclei. The spindle cells are at the periphery of the masses, and these endothelial cells occupy the centers. There is no degeneration or desquamation of the cells in the centers of the masses. These spindle cells often surround islands of fibrous connective tissue, which is rarely seen in carcinoma. The round cell masses are not so prominent, but are scattered loosely through the fibrous framework in rows or groups. They also show intimate relation to the fibrous cells. The nuclei are small, round and vesicular. There are also numerous fibroblasts, endothelial cells and easinophiles. The fibrous framework is dense and in excess of the cellular areas. In places there is an appearance resembling hyaline degeneration. There are no typical areas of myxoma or enchondroma. The section has the archecture of a mixed tumor of the parotid or salivary gland but the cellular appearance of a round and spindle cell endothelioma.

A section from the upper part of the tumor shows a different picture. Here the scirrhus arrangement is not seen, but the round cells predominate. In places the gradual transition from round cells and fibroblasts to definite spindle cell groups is seen. Sections from other parts of the tumor show much the same arrangement as is seen in the main body of the tumor. In the polyp mass in the jugular vein at one side is seen a definite perithelial arrangement of the round endothelial cells about small bloodvessels.

Histological Diagnosis—Mixed tumor, more likely of the salivary gland than of the parotid; round and spindle cell sarcoma. Endothelial in origin with evidence of perivascular growth.

Dr. Maccallum—Case 1. Pathological report—The tumors were pedunculated but with broad base. Section showed considerable disarrangement of the muscle. Down among the muscle fibers there were long, ramifying, racemose glands actively secreting mucus. There was no invasion or destruction of the underlying tissue and no change in the nuclei. There are cysts in some places due to obstruction of ducts. It is not carcinoma, but rather adenoma. These adenomata occur in the stomach, duodenum, ilium, jejunum and large intestine. Etiology—There is a suggestion that they are due to inflammatory processes.

MEETING HELD JANUARY 7, 1907—DR. BARKER IN THE CHAIR.

Exhibition of Case—Dr. Thayer. Boy, age 15; complaint, shortness of breath and swelling of his stomach. The family history is negative. Personal history shows at 13 some affection of the eyes, with swelling and photophobia. The present illness began five weeks before admission to the Hospital with a cough and shortness of breath. On admittance the physical examination showed puffy eyelids, a pallor, a few patches of leucoderma and a few slightly-enlarged glands. Just above the right clavicle, however, there was a bunch of enlarged glands about five centimeters in diameter and discrete. In the upper chest there was a remarkable dulness. The spleen was enlarged, and on palpating it firm, hard, irregular bosses were felt. The liver was also considerably enlarged. The temperature at the time was slightly elevated and irregularly remittent, and occasionally intermittent. A trace of albumen was present in the urine, with a few hyaline

and granular casts. The blood showed a moderate secondary anemia. There was nothing remarkable about the eyegrounds. Last week the opsonic index to the tubercle bacillus was 0.9. No tuberculin test was made on account of the existing fever. Fowler's Solution was begun in three-minim doses and increased up to 10, when an iritis developed. Then mercury and potassium iodide were given, and the iritis cleared up in a week. Under the Fowler's Solution the spleen and glands decreased in size, but when it was stopped they increased again.

The enlargement of the spleen was very great; in fact, so much so that a similar size is seen only in a few conditions. Therefore, at first leukemia was thought of, but ruled out on account of the blood examination—the differential count. Malaria could also be ruled out after an examination of the blood. Banti's Disease could not be concomitant with the pulmonary condition and the enlargement of the glands. Could it be due to lues? Such a condition might be possible, but the lesion in the lung is hard to explain.

Primary splenomegaly may be tuberculous in character, and tuberculosis might account here for the condition in the lung. The fact that the patient is a negro helps this view; but tuberculosis existing without adventitious sounds and with such a consolidation as the physical signs would indicate is not likely. The opsonic index is against this also, although it is true that it was only tried once. Either Hodgkins Disease or lympho-sarcoma might account for the glands, the spleen and the intermittent fever. The question as to which is a serious one. Lympho-sarcoma was rather in favor because the enlargement of the glands is relatively small, for Hodgkins and the lung infiltration is so marked. A gland removed showed typical Hodgkins Disease. No normal tissue was seen, but many small lymphoid cells, very numerous large cells with large, budding nuclei and abundant eosinophiles. The comparison made between the radiograph and the clinical picture is of interest. The clinical findings show a remarkable area of flatness, taking in the whole manubrium and extending under the right clavicle as much as 8 centimeters from the midsternal line and 4.7 centimeters to the left. From this point on the right clavicle the line of the area of flatness came in toward the sternum, almost reaching the sternal edge at the fourth costal cartilage. On the left the line came straight down from the clavicle. Both to the right and to the left of this area there was a narrow border of dulness, and on the right side a marked tympanetic note over the remainder of the chest in front. The radiograph showed a deep shadow over the whole of the right upper chest, with a sharp outline below, the line not corresponding with the line of flatness on percussion.

The areas of tympany are areas of relaxed lung near an area of consolidation.

One striking feature of the case needs to be mentioned, and that is the entire absence of pressure symptoms. In all cases of neoplasm infiltrating the lung seen before by Dr. Thayer there have been pressure symptoms and dyspnea.

MEETING HELD FEBRUARY 4, 1907—DR. BARKER IN THE CHAIR.

Exhibition of Cases—Dr. Thomas. Patient is a male, age 27. The family history is excellent. Personal history—Patient is strong, active, with

no previous history of importance, except the excessive use of tobacco for the last 10 years. For the last few years the patient has been living in the Maine woods all the year around, and gives a history of repeated exposure to cold and of long walks of 25 to 30 miles a day. In 1900 his feet were frozen very severely, so much so that there was a question as to whether or not parts of them would recover. In August, 1905, he began to have trouble with his left leg, which would give out on him. At first he could continue walking, but in October, on coming to New York city and changing from moccasins to shoes, it became almost impossible for him to walk more than a short distance. Now he is a little better. During all last year he received no treatment. In 1906 he ran a short distance on his toes and ruptured a small bundle of muscle fibers. Since then has had no trouble with his right leg. All last summer he had a lot of trouble. The left foot gets cold and looks bloodless. The circulation is evidently not good. During the last year the patient has suffered with a dead, steady pain in the anterior part of left leg that is aggravated by walking, but does not come on all the time when he walks. Now when he walks the calf of the leg becomes cramped and is very painful. If he stops he is very soon relieved, but it begins again almost as soon as he starts. Last night he walked eight blocks, which is a very long walk for him. Physical examination—The urine is negative-acid, no albumen, no sugar; pulse strong; blood pressure is equal to about 150 milimeters of mercury in the right arm. The left leg is smaller than the right; the largest difference is below the knee, where it is over two centimeters smaller. However, the legs seem equally strong. On squeezing the blood out of the toes of the left foot it takes a long time to flush again. The pulse cannot be felt in the anterior tibial nor in the dorsalis pedis arteries, but it is to be felt in the posterior tibial. The left foot is paler than the right. The patient rises on toes with apparent ease and apparently no pain at the beginning, but in a few moments the pain becomes very severe, and passes off very rapidly on resting.

A number of terms have been used in the description of this trouble—intermittent claudication, intermittent limping, intermitierendes hinken, dysbosia angiosclerotica.

A similar condition is known in horses. Charcot, in 1858, wrote the first description of the condition occurring in man. He wrote a good deal about it, but no attention was paid to it. Later an article also appeared written by a Russian. In 1898 Erb wrote on the subject.

Charcot's first case was due to a traumatic aneurism of the iliac artery. Erb shows, however, that most of the cases are due to a disturbance in the small vessels rather than a gross disturbance. He emphasizes the importance of feeling for the pulse in the feet. Out of 700 pair of feet he found the pulse to be present in 99 per cent., excepting those cases with extreme arterial sclerosis or some skin trouble.

Pathology—On section we find an obliterating arteritis; some show atheroma. Here there are none in the vessels; the vessels cannot be seen. The general condition is an obliterating arteritis.

Etiology—This particular patient is young, since the condition has seldom been seen in patients below 30, most being 40 or 50. Erb says that the particular causes are tobacco and exposure to cold. A surprising number

of cases come from Russia. Manlauffel (V. Manlauffel—*Centralblatt f. Chir.*, 1902, p. 85) reports some experiments on the effect of exposure of the hind feet of guinea pigs to alternating cold and heat. He claims that he can by this method produce in them the same condition found in man. The condition here is probably due to cold. Women are almost exempt. In 150 cases by Erb seven were in women. A theory advanced to explain the condition is that the muscle has not enough blood supply for its demand during exertion, although it may be sufficient during rest, and the consequence is the spasm and consequent pain.

From where the pain comes is a question. The characteristic symptom is common to several causes. It may come from trouble in the larger vessels higher up; it may come in the arm. One case has been described in a tongue. Last year Dejerné reported a case where there was intermittent claudication due to a disturbance from the central nervous system to the blood supply. He suggests that the Cheyne-Stokes is an intermittent claudication of the respiratory center.

The treatment is warmth and potassium iodide.

It is an interesting fact that the theory has been used to explain the pain in angina pectoris. An arterial sclerosis of the coronary arteries is supposed, and on exertion an ischemia, with a consequent spasm of the heart muscle, the pain being due to the cramp of the heart muscle. This was one of the old theories, but not explained on the ischemia.

Dr. Howell performed an experiment on the muscle of a calf, stimulating it through the nerve. On one side he tied off the circulation, and on stimulation found the muscle to go into a constant clonic spasm. The curve then dropped and the contractions became less. Before the end of the experiment, however, the apparatus broke.

Dr. Barker suggested that perhaps the gastric crises in Tabes might be explained upon the same ground, and remarked upon the scarcity of the cases of this condition, in view of the fact that we see so much arterial sclerosis, so there is probably some other cause besides arterial sclerosis causing the angio-spasm.

Report of a Case of Thyrotomy—Dr. Rosenheim. The case is of interest for two reasons, namely, the location and the perfect result. The patient complained of choking spells and inability to speak. Two years ago (1904) swallowed a shoe-button hook. For the last two years has been troubled with dyspnea and choking at night; would get blue in the face and spit up blood. At night the patient breathed through the mouth. The tonsils were large and adherent to the anterior pillars, and there was a good deal of adenoid swelling.

At the first examination there was only a narrow cleft for the patient to breathe through; slight cyanosis and marked stridor. There was also a depression of the lower part of the sternum.

Operation—Tracheotomy and thyrotomy up to the hyoid bone. In the region of the right ventricle was found a mass of granular tissue and a complete absence of vocal cords on the right side. Now, however, there are distinct false and true cords to be seen. The hook and mass had the odor of a decayed tooth. The tracheotomy tube was removed in two weeks. The tonsils and adenoids were removed at a later date.

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Associate Editors:

THOMAS R. BROWN, M.D. | HUGH H. YOUNG, M.D.
ROBERT REULING, M.D. | JOSE L. HIRSH, M.D.

BALTIMORE, JUNE, 1907

DEADLY VACATION DAYS.

AT this joyous season two preventable diseases begin a four months' carnival. The medical profession is able to prevent either of these diseases—or, both of them. In one case the task is difficult; in the other it is easy. In the one case the medical man must impart to his lay assistants detailed information and a technique of some rigor; the charitable public must be convinced that he can do what he proposes and funds must be provided for dispensaries, nursing, and materials; and, after so much preparation, the medical man must invest liberally of his time, patience and tact in each individual case. The simpler task of prevention requires only that the medical man shall recognize the disease early in its course, and that he shall enforce an easy technique of antisepsis during a relatively short period of infectiousness. The two tasks offer another contrast. The first and more difficult one promises a larger reduction in the general death rate, and should be, on this account, more attractive to public health officials. A complete conquest of this cause of death would require, indeed, governmental activity on a rather large scale. The complete subjugation of the other disease could be accomplished by practicing physicians without the co-operation of public health officials, without a line of legislation, and without a dollar of public funds.

But there is a medical conspiracy to solve the problem which is more inviting to public health officials, while, on the other hand, that problem which physicians can solve unassisted is apparently uninteresting to physicians, though it exercises official minds mightily, and causes the expenditure of large appropriations.

It seems, then, that the medical profession has preferred the task in which it can be but partially successful to the task which lies wholly within its abilities. The explanation is quite simple. It indicates merely a distinction between a small class of medical men who realize and exercise their power to restrain one cause of untimely death, and a larger class of medical men who do not realize, or at all events do not exercise, their power to prevent another sort of untimely death.

THE DIETETIC PERIL OF INFANCY.

IN any large city, having a population normally distributed as to age, and having a normal birth rate, between one-fourth and one-third of the total annual mortality falls on the period of life under five years. For Baltimore this means that one-tenth (the youngest tenth) of the population suffers nearly one-third of the mortality. Of this ghastly toll, more than half is

exacted by means of gastro-intestinal disorders, attacking children under two years of age. A successful campaign against this cause of death would cut more points of the general death rate than could possibly be effected by a contest with any other single agent of mortality. But this dietetic peril does not apparently interest public health officials very deeply, though private physicians have made a strong combination against it.

It is against infantile diarrhea that medical men have conspired. It is not an easy fight, but it is the pediatricians' own, and in it they have earned a special distinction, which physicians in general practice might contemplate with advantage. For many years past the pediatrician has been, among medical men, the best exponent of the scientific faith that is in him. No one can gainsay the merits of modern surgery or of modern obstetrics. Partly by learning what to do, but chiefly by learning what to avoid, surgeons and obstetricians have conferred incalculable benefits on mankind, but the remarkable growth of their technical efficiency in the last 30 years has been confined rather strictly within professional lines, and has not greatly increased the lay citizen's power of self-defense.

But the pediatrician is obliged, by nature of his problem, to communicate his knowledge freely to mothers and nurses in order to safeguard certain special dangers to helpless childhood. He needs lay allies all the time, and must make new ones as often as a new patient comes under his care. Thus the pediatrician has become the propagandist *par excellence* of dietetic hygiene. The rewards have been very rich, not only in life saving, but also in developing a superior quality of citizenship in a profession whose civic virtue is apt to be anemic.

THE BABIES' MILK FUND ASSOCIATION.

An example of a medical conspiracy to circumvent one cause of untimely death is the Babies' Milk Fund Association of Baltimore City. This new association takes over the work which the Thomas Wilson Sanitarium has carried on with increasing success since July, 1904. Beginning with four milk dispensaries, a fifth was added in 1905, and three new ones in 1906. The work of these dispensaries is now too large for the hands in which it originated. The service, we are told, must be "further increased until it becomes possible to offer the best milk to all infants for whom it cannot otherwise be provided." Last year 754 infants received milk from the eight stations and during the summer as many as 250 infants were supplied daily. More than 100 remained on the rolls throughout the year, and on May 1 170 were being supplied each day. The utility of these dispensaries to physicians is shown by the fact that 161 physicians sent babies to the dispensaries last year. The cost of this charity so far has been somewhat under $10 for each infant, and 60 per cent. of this amount has been paid by the beneficiaries. A very large mortality should, under ordinary conditions, be expected among these artificially-fed babies. Last year the mortality among the dispensary-fed babies was 10½ per cent. According to past experience, a benefactor of this charity may expect the following results: A subscription of $200 develops an additional investment of $300 by parents, and $500 will provide safe food, with instructive nursing, under medical supervision, to 54 infants, of which number five will die and 49 will be carried safely past their period of dietetic danger. Such is the

outlook in the light of recent experience, but the value actually created by this work is much greater, for one should take into account the growth of life-saving knowledge among the poor. "It is felt," the founders of the association say, "that a beginning only has been made. It is hoped that more and more the dispensaries will become not only stations for the distribution of milk, but centers of information, where mothers who have no family physician can come to doctor and nurse for advice in all matters pertaining to the care of their children."

THE UNPROTESTED SACRIFICE TO TYPHOID.

ANOTHER peril of vacation days is typhoid fever. Resting in winter, awakening in spring, seed time and harvest from June to December—the seasons are not more obedient than typhoid fever to the world's orbital swing. No agent of untimely death is more answerable to man's intervention than is the typhoid bacillus. It is one of the feeblest of parasites, pathogenic for man alone, unable to maintain itself long outside the human body, having but one easy mode of entrance into the body, and controllable modes and times of exit. But there is no medical conspiracy to circumvent the typhoid bacillus. Health officers will soon publish their customary advice to boil all drinking water, and to be very suspicious of the water at amusement and summer resorts. We shall revive the annual talk about unprotected watersheds, about filtration, about dairy and milk infection. We shall discuss flies, and forecast the beneficent results of a sewerage system lacking yet seven years of completion. But the simple thing necessary to control the spread of typhoid fever we will not do. Every doctor in general practice in Maryland sees two or three cases of typhoid fever every year. Four thousand such cases will be recognized, and 300 will die. These 4000 cases of acute infectious disease will engage the expert professional services of approximately 2000 physicians, some of whom will attempt to control the infectiousness of their patients. But in a majority of instances the dejecta will not be disinfected, nor disposed of with anything like stringent consideration of their infectiousness.

If it were learned that the quarantine physician sweeps the debris of his smallpox wards out upon the lawn, we should have a portentous scandal, though the quarantine hospital is remote from any center of population, the people of Maryland are well immunized by vaccination, and smallpox is very uncommon. Typhoid fever is so common that a majority, probably, of the population above the age of 35 years have been attacked, but it is not apparently scandalous for a physician to permit the disposal of typhoid excreta, without disinfection, and in any way that may seem most convenient to careless or ignorant attendants.

In many large cities sanitary works of great proportions, and enormous cost, are undertaken for the exclusion of water-borne diseases, and the typhoid rate is the index of their efficiency. Intelligent people believe that these expensive works are necessary for the prevention of typhoid fever. But the fight against typhoid requires no elaborate or costly preparation. It can be won easily and conclusively at the bedside. The physicians of Maryland can in four years make cases of typhoid fever so scarce that students in Baltimore medical schools would be obliged to go to other cities, as Munich students do, for the sake of studying typhoid fever.

Correspondence.

ACTION OF THE BALTIMORE COUNTY MEDICAL SOCIETY ON THE QUESTION OF LIFE INSURANCE EXAMINATIONS.

Mt. Washington, Baltimore Co., Md.,
March 21, 1907.

Dear Doctor—At the January meeting of the Baltimore County Medical Association the following resolution was adopted:

"*Resolved*, That the reduction of the medical examiner's fee for medical examinations to $3 from $5 by a number of the life insurance companies be rejected; that the members of this association and other members of the medical profession in Baltimore county be asked to endorse the action of this association."

We believe the following reasons are good ones for asking for this endorsement: First, the investigation of life insurance companies of New York have exposed no irregularities in the medical departments, yet the order to retrench and reduce expenses has reduced the examiner's fees almost 50 per cent. This lack of appreciation of such a record of faithfulness by the insurance companies should not be brooked by the profession. Second, medical examinations for life insurance is a work carrying with it a great responsibility to the company, to the applicant and to the medical examiner, and is of a special high order, requiring a thorough knowledge of physical diagnosis, clinical microscopy and urinary analysis. To make a wise selection or a just rejection of a risk requires a well-balanced judgment, for which the examiner should receive a just and ample compensation. The former fee of $5 scarcely compensates him today for such assumption. Lastly, the cost of living has increased fully 50 per cent. in the last 10 years and salaries in the various walks of life have been more or less increased, while some of the life insurance companies, instead of increasing their examiner's income from fees, have endeavored to diminish it almost one-half. The medical profession of the United States is aroused to a just indignation at the action of these life insurance companies, and the American Medical Association calls upon the profession to stand together in this fight.

Doctor, will you kindly express your sentiment on this question by answering the question either "Yes" or "No" on the enclosed postal card and returning it to us by the next mail?

Fraternally yours,
William J. Todd,
Samuel T. Earle, Jr.,
Commitee.

Mt. Washington, Baltimore Co., Md.,
May 16, 1907.

To the President and Members of the Baltimore County Medical Association:

Gentlemen—Your committee, appointed to request the members of this association and other members of the medical profession in Baltimore county to endorse the action of your association rejecting the reduction of medical examiners' fees from $5 to $3 by a number of the life insurance companies, beg leave to make the following report:

We had a circular-letter printed setting forth our reasons for this request. We enclosed a copy of this letter and a postal card for the answer to 105 members of the medical profession, members and non-members of our association practicing in Baltimore county. We received answers from 82, all of which heartily endorse your action.

Your committee beg leave to suggest that this report, together with the circular-letter mentioned above, be sent to each of the medical societies in the State of Maryland, requesting them to take the same action; also to the medical directors of each of the insurance companies who have reduced their examiners' fees.

Most respectfully submitted,
William J. Todd,
Samuel T. Earle, Jr.

QUALITATIVE EXAMINATION OF THE URINE BY TROMMER'S TEST—KLETZINSKY'S FLUID.

Baltimore, May 8, 1907.

Maryland Medical Journal:

Messrs. Editors—The writer, not being an analytical chemist, has often struggled in vain with the uncertainties of Trommer's test for glucose—"hoc opus, hic labor est."

All the authorities admit that "it is very difficult to hit upon the right proportion of potash and copper."

In Heller's "Pathological Chemistry of the Urine," translated by Dr. Moore of Edinburgh (Fannin & Co., Dublin, 1855), the following valuable suggestion is given. After stating the uncertainties of Trommer's test, he goes on to write: "It will always be advisable, in using Trommer's test, to employ a compound pro-

posed by Dr. Kletzinsky, one of the assistants in the laboratory at Vienna. This fluid is composed of four parts of a saturated solution of sulphate of copper, six of glycerin and eight of caustic potash. Sulphate of potash crystallizes, and is separated by filtration; the urine is boiled with some of the filtered solution, by which the reduction of copper is effected. This test is particularly suited to unpracticed experimenters."

The fluid, if properly made, is of a very dark blue color, and has the consistence of syrup. Quandt Bros., Howard and Baltimore streets, Baltimore, kindly prepared the test for the writer; their habitual skill was fully shown by the satisfactory manner in which the fluid worked.

To use the compound, add one-half drachm of the fluid to one drachm of the suspected urine, and boil. "If the urine contains sugar, it becomes first brownish, then of an intense yellow, and a yellowish-brown precipitate quickly collects at the bottom. If no sugar is present, the fluid itself becomes green with streaks of green."

Tyson, in his work on the urine, recommends Trommer's solution as a check-test. After describing the method of testing by heat, he advises that a second test by Trommer's solution "should be made and set aside, without the addition of heat, for from 6 to 24 hours. If sugar is present, a similar precipitate of suboxide of copper will take place. If the reaction is at all doubtful, it is important that this check-test should be made, since, as Nebauer points out, most of the other organic substances which reduce the salts of copper do so only when heated or after long boiling." This check-test is very effective with Kletzinsky's fluid, as the writer can testify.

In summing up, therefore, though the subscriber is not a chemist, he hopes he will be pardoned if he ventures to list the advantages of Kletzinsky's fluid for the qualitative examination of the urine:

The compound is stable and permanent; will "keep" indefinitely.

There is no mixing of solutions.

There is very little danger of doubtful reactions from prolonged boiling; if glucose is present, a few seconds of boiling will show the "intense yellow."

Tyson's check-test, which is very important in cases of doubtful reaction, can be very easily made with this fluid—one-half drachm to one drachm of the urine.

In short, to be convinced of the value of the advice of the eminent chemist, Heller, in reference to using Kletzinsky's fluid, the writer has only to say—try it. Yours very truly,

LEWIS W. KNIGHT.

Medical Items.

THE House of Delegates made a singular mistake in nominating men for two positions on the Board of Medical Examiners. They brought in six names for two positions. In other words, they failed to nominate. This error has been made by the House of Delegates once or twice before. It was the duty of the House to express its own choice among any number of names which might have been put before the House of Delegates. They should have balloted until two out of the six were chosen as the nominees of the House, and by all rules and precedents these two nominees were entitled to the support of the members of the House when the election was held by the Faculty. Instead of proceeding in this way, the House reported six names and was then in the position of being unable to support its own action by their individual balloting, and failing to advise the Faculty concurring its own deliberations on the membership of the Examining Board.

What they did was to put six names in a column on the blackboard, and members of the Faculty, having no advice and no time for inquiry, naturally voted the two names at the top of the column, electing them. If anyone had raised a point of order after the election, and the point had been ruled upon according to authority and precedent, the election would have been set aside and the House of Delegates required to do their work over again.

THE week was an unusually active and interesting one for the physicians, many of them being interested in the concurrent meetings of the Conference of Charities and Corrections and of the Federation of Women's Clubs. On Friday night the Conference of Charities and Corrections devoted special attention to tuberculosis. Addresses were made by Dr. Laurence Flick of Philadelphia and Dr. Henry Barton Jacobs.

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THE LOGICAL BASIS OF NEURASTHENIA.

By A. K. Bond, M.D.,
Baltimore.

PAPER PRESENTED TO THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND AT ITS ANNUAL SESSION, APRIL, 1907.

In an article entitled "A New View of Sleep," published in the Maryland Medical Journal October, 1905, I stated at some length the principles which seem to me to underlie sleep, awakeness, dreams, hypnotic states, mania and insomnia.

In the present paper I desire to show how my theory of nerve activity applies to those fatigue and debility states of the nervous system which are clinically grouped under the headings of neurasthenia, melancholia and hysteria.

If, as I there stated, the fundamental state of nerve tissue is one of quiescence (expressed in the higher brain reaches by sleep), and every activity of nerve tissue (awakeness and lower-center reflex) is due to a definite excitant, what should we expect when the nerve centers fall into a state of overfatigue or general debility? Are the diverse and multitudinous and apparently conflicting symptoms of the group of neurasthenias above mentioned explainable under the theory which I applied so satisfactorily to sleep and its associated conditions?

It is easier to see why the inert conditions of neurasthenias result from fatigue than to trace to the same causation neurasthenic nerve excesses and hyperesthesias; yet, on careful scrutiny, both are seen to spring from the same source and own to the same law.

In this paper I shall not attempt to define neurasthenia, for its symptoms may not be the same in any two cases, nor to differentiate it from melancholia, which is simply its most prominent manifestation in certain individuals, nor to delimit it from hysteria, which is a neurasthenia with the sexual abnormalities especially accentuated. I do not believe that medical writers would have

any doubt concerning hysteria's place in the classification of disease or see any mystery about it if the sexual nerve states of woman were not very complicated and very difficult of comprehension by the male mind. I am prepared to support this statement, but its defense is beyond the scope of the present paper.

My article on sleep was based upon the proposition that all nerve activity is a response to a definite stimulus. I now offer in explanation of the neurasthenias a supplemental proposition that

ALL NERVE RESPONSE IS DUAL;

that with every nerve impulse is associated its limiting impulse; that when nerve force is called into activity there is evoked likewise its control, to restrain it within its proper bounds of area and intensity and duration.

Heretofore we have recognized limitations, but have regarded them for the most part as due to passive resistances of adjacent tissues or to the natural waning of the force evoked. My proposition is that with the awakening of any nerve force there is a simultaneous awakening of a definite companion force designed to control the former.

Illustrations.—When any center of the brain is aroused to activity it is clear that there must be at the same moment aroused a force capable of directing the activity along one of many possible channels, of determining which of many allied nerve centers shall be joined in its activities, of limiting the amount and the duration of the designed effect. (This associated controlling force need not follow exactly the same channels as its fellow.)

Thus when a man receives an intolerable insult his brain response may be either a blow or a word. If the nerve centers and strands for a blow alone are set in activity, those for words must be shut out, and *vice versa*. Moreover, the choice between the upper and the lower limb must be decided and the intensity and duration of the blow must be determined. This involves a dual nerve discharge, of activity and of control. Like examples, in connection with automatic reflexes, are not difficult to find.

The expert pianist, for instance, while thinking of something else or conversing with a friend, has awaked in his automatic centers impulses, coupled with restraints. The impulse to strike a key must evidently be coincidently associated with a companion impulse which determines the finger to be employed and limits the force and duration of the stroke. Each of the multitudinous, bewildering, often lightning-brief impulses, which goes forth in the rendering of a concert must be dual—active to call out the finger stroke, restraining to delimit the nerve outgo to the proper finger, and to moderate, with infinite delicacy, the intensity and expression of the stroke.

Application to Neurasthenia.—This duality of impulses applies in all the countless activities, mental and bodily, of our lives. Let us see how beautifully its appreciation illumines the study of the

neurasthenias, when we realize that we have to deal not always with cells too fatigued or weak for active impulse, but possibly with cells too fatigued or weak for the twin impulse of restraint.

Taking illustrations somewhat at random (for the field of selection is enormous), we note that psychasthenia may present in one form a brain inertia of such intensity that the mind is almost a blank, and the psychic centers can hardly be aroused to any thought impulse whatever. In another form it may present a melancholia, where the impulse to think along certain narrow, morbid lines is strong, but the fellow-impulse to limit the intensity and duration of the thought is inefficient.

Again, the symptom of Muscae Volitantes is due to outgoing of thought in the contemplation of normally-present impressions upon the retina, with inefficiency of the control-thought which usually in health limits the intensity of the contemplation, telling our subconsciousness that the phenomena are of no importance. This is a fair example of those innumerable symptoms presented by the neurasthenias in which excessive attention to trifling details and introspection are prominent.

Since excessive attention disorders the circulation and disturbs the functions of the part or organ to which the attention is directed, it is easy to explain the congestions, paraesthesias and secretion perversions which swarm in the train of grave nervetires. Moreover, morbid secretions eventually pollute and impoverish the blood streams, enfeebling and exposing to disease invasion all parts of the body.

Morbid Fears.—Dreads of divers sorts (fear of crowds, fear of contamination, fear of being afraid) arise from inefficiency of the normal control impulse to limit the impulse of attention within its proper bounds, allowing disturbing thoughts to thrust in from neighboring centers, until the mind becomes confused and confidence lost.

So, too, in the patient who rises a dozen times at night to turn off the gas-cock; the control impulse which should damp the once-effective impulse is incompetent.

Sexual Symptoms.—These, too, are attributable to the enfeeblement of one or other of the dual impulses under consideration. In some cases the sexual nerve centers are too sluggish; in others the control is imperfect and the unrestrained orgasm reaches its crisis too soon. Humiliation fixes the attention excessively on the sex organs and wearies the brain with details which should be confined to automatic centers.

Many hysterical states are low-toned, prolonged orgasms; others are general nervous exhaustions following incessant teasing of the sexual centers. The low-toned orgasms are accompanied by morbid sensations in various parts of the woman's extensive sexual system and by a psychic display which embraces every possibility of her extraordinary emotional equipment. In ascribing hysterical phenomena to sexual orgasm I would state that sexual orgasm in woman often (if not, as I suspect, in most

patients, yet certainly in very many), though physically and nervously perfect, in its development proceeds from inception through crisis without the slightest experience of desire or the least appreciation of its meaning to more passionate minds. Hosts of women experience the phenomenon in one or other of its manifestations without any suspicion that it is exhausting when overfrequent and the possible cause of health wreck.

Other Symptoms.—Neurasthenics are, some of them, irresolute and easily influenced; some of them exceedingly obstinate. In one class the will centers are enfeebled; in the other the control centers bear the brunt of the fatigue.

The vasomotor centers show this dual distress in a very decided way, deficiencies of tonus and abnormal tensions being among the most distressing experiences of our patients. In the neurasthenias of the menopause and after double ovariotomy it is very evident that the control stimuli of the lost ovaries are sadly missed in activities of the nervous system.

The pains felt by neurasthenics in various regions do not directly concern us now; they are the results of the blood pollution and the faulty tensions of blood vessels already discussed. The end result of all in the worst neurasthenias is the destruction of the special functions of the cells involved.

A Race Question.—Civilization involves two great factors—quick, intense nerve response, and quick, strong control impulse; intelligence and self-control. Some races attain to the former, but fail of the latter, which is evidently the higher function. Dominant races combine the two. In some races self-control seems to be developed by generations of education; in others, education seems to produce no marked improvement in this direction. The same is true of individuals in any community of highly civilized people. They must be left to their less-developed ways or controlled by their neighbors.

To preserve in the education of an individual or of a nation the proper balance between development of quick intellect and of its normal controls is very difficult. In America at present the former seems to have the ascendant. We do things to excess in every line of activity. In that respect we are a nation of neurasthenics.

Prevention of Neurasthenia.—The basis of a healthy nervous system is a healthy body. This predicates comfort and quietude of the mother in prenatal months. Neurasthenic parents should bring their children up in a healthful country district and protect them from the abnormal nerve strains of fashionable education and social life. Their children will have inherited sufficient nerve quickness. A perfect control of this quick response is the thing to be sought. Later, a livelihood free from excessive nerve strains should be chosen. Excessive action and excessive emotion of every sort, social, political or religious, should be shunned.

Treatment.—In view of the proposition with which this paper began, the principles of treatment are evident. Both the nerve activity and the nerve control must be restored to normal vigor.

Three things are needed—removal of the cause of exhaustion, rest to the exhausted nerves, and roboration of them.

To discover the cause—the organ or function really at fault, the sexual teasing, the concealed emotion or worry—demands medical discernment of a high order. The hurried doctor, the unsympathetic doctor, the materialist, should not attempt to treat such cases. If he does, the patient is liable to drift into chronic invalidism or insanity or to acquire a drug habit.

Thought exhaustion cannot always be met by body rest, which is often needed as a first step in treatment. For rest of the thought centers the attention of the patient must be diverted to unwonted themes; best, to those which are simple and easy to comprehend and which lead into the open air and the sunshine. Anodynes, strong enough to prevent deep or lengthy reflection and to secure restful sleep, are often of value, but the patient should not know what he is taking.

The control forces may be renewed by lessening the number of nerve outgoings requiring control and by giving the regulation of the patient's activities into the charge of a well-trained, well-balanced attendant. Certain drugs which incline to indolence are of value here as aids.

Roborants are to be directed in general to the building of the whole body. They are very numerous, including many agencies besides drugs. Nourishment to the fullest capacity of digestion, careful exercise as soon as possible, sunlight, fresh air tone the whole system. Change of scene, new companionship, new enthusiasms, simpler religious faith, quickened hope invigorate the higher centers. The higher controls may be strengthened, too, by association with individuals of sturdy character and by instruction concerning the reasonableness of self-control and the wrong of the cultivation of invalidism. The doctor's example in these things is often the chief incentive to convalescence.

The patient who has not sufficient self-control to keep off of pet worries and unwholesome thoughts must be forced to diverting companionship and physical labors (more or less mild) during every moment of the day. Especially must morning reveries before rising be prevented. Bed life in hospital wards, even, may favor this form of neurasthenia.

DISLOCATION OF A CARTILAGE RING OF THE TRACHEA CAUSING LOSS OF VOICE.

By S. B. Muncaster, M.D.,

Washington, D. C.

I was called to see a patient in December, 1905. When she began to speak her voice sounded worse than a foghorn. I could not understand a word she attempted to articulate. She wrote on a slip of paper that her "voice left her after an operation performed

in Baltimore for stitching up the kidneys." On the day before she left for Baltimore I treated her eyes and nose, and her throat was then in good condition and her voice normal.

As my area is confined to the head, I did not care to undertake her case. Upon her written request to do something for her, I consented. She then wrote: "The physicians in Baltimore were of the opinion that this trouble was from taking an anesthetic."

On examination of her throat I could not find anything to cause such an unhuman sound. I examined her neck and found a swelling on the left side of the trachea just below the larynx; the right side was curved in. I made a pressure on this swelling, and discovered that the cartilage ring of the trachea was dislocated. I then made a pressure with considerable force and the cartilage slipped into position. Immediately she began to talk normally. I had her remain on her back in one position until the next day. When I called the following afternoon she could converse without any difficulty.

When this patient went to Baltimore she weighed about 97 pounds, though her normal weight was about 125 pounds. Since the operation her weight has increased to 110 pounds and she is in fairly good health. The displacement of the cartilage must have been due to accidental pressure or perhaps to a change of position during the operation. Her neck was so emaciated that one could almost count the rings of the trachea.

Current Literature.

REVIEW IN MEDICINE.

Under the Supervision of Thomas R. Brown, M.D., Baltimore.

THE BACTERIOLOGY OF THE RESPIRATORY TRACT WITH ESPECIAL REFERENCE TO THE INFLUENZA BACILLI.

Davis (*Journal American Medical Association*, May 11, 1907) contributes a long and interesting article on the subject of the bacteriology of the respiratory tract as regards the influenza bacillus. The study was carried on with a view of determining the frequency of the occurrence of influenza—like bacteria in the sputum and throats of persons afflicted with the various infectious diseases, and also of comparing such bacilli for the purpose of determining the possible variations which might lead to a subdivision of the influenza group. The cultures were made either from swabs of the throat, or from sputum expectorated into a sterile Petry dish. The specimens were washed to get rid of the sapprophytes, and cover-glass specimens and cultures on pigeon blood agar were made. Of 68 cases of whooping cough studied, influenza-like bacilli were isolated 61 times, and during the

coughing paroxysm myriads of these bacilli were scattered through the surrounding air. Pneumococci were found in every specimen, and the micro-coccus catarrhalis was found in large numbers in some of the cases.

Of 23 cases of measles the influenza bacilli were present in 13, in some almost in pure culture. Of 11 cases of varicella, influenza-like organisms were isolated in 7, streptococcus in 8, diphtheria bacilli in 1, and micrococcus catarrhalis in all.

Davis then discusses the presence of influenza bacilli in other infections, the agglutination of influenza-like bacilli, and the phagocytosis of influenza bacilli. The summary and conclusions of this admirable and interesting article are as follows:

1. Influenza-like bacilli are very commonly found in the upper respiratory tract in various infectious diseases and especially in whooping cough. Occasionally they occur in normal throats.

2. Various organisms occur in the discharge in otitis media, the streptococci being the most common; occasionally influenza bacilli were found.

3. The micrococcus catarrhalis is a common inhabitant of the respiratory mucosa in infectious conditions and in some cases exists in nearly pure culture. It does not appear to produce specific lesions.

4. The influenza-like bacillus from whooping cough is pathogenic for man; its specificity is doubtful. Present data permit us to consider these bacilli as secondary invaders in all the diseases in which they are found. A primary invasion at times should be considered a possibility.

5. Influenza-like bacilli are readily taken up in the test-tube by unwashed leucocytes and to a less extent by washed leucocytes. This spontaneous phagocytosis is not affected by varying the concentration of the salt solution between 0.6 per cent. and 1.4 per cent.

6. Injection of these bacilli into animals causes the production of specific agglutins and probably also an increase in opsonins in the serum. Because of the occurrence of spontaneous phagocytosis and agglutination in such sera the determination of the opsonic index for these bacilli is rendered unreliable.

* * *

THE EARLY DIAGNOSIS OF INFECTIOUS DISEASES BY THE RECOGNITION OF THE GENERAL INVOLVEMENT OF THE LYMPHATIC GLANDULAR SYSTEM.

Vipond (*British Medical Journal,* December 15, 1906) discusses in an interesting paper the whole involvement of the glandular system in the various infectious diseases, calling especial attention to the value of this procedure in arriving at an early diagnosis. He discusses in turn, with reports of cases, measles, glandular fever, rubella, chicken-pox, mumps, whooping cough, scarlet fever, diphtheria and erysipelas. Of these, he reports 20 cases of measles, 7 of rubella, 17 of glandular fever, 11 of chicken-pox, 6 of erysipe-

las, 8 of mumps, 14 of whooping cough, 11 of scarlet fever and 12 of diphtheria. The conclusions of this article are as follows:

1. The nodes are enlarged in infectious diseases.

2. They are enlarged some days before the development of the disease. I have found them to be enlarged and tender seven days before the rash of measles appeared.

3. The enlargement is most marked between the ages of from 3 to 18 years.

4. The enlargement is not produced by the irritation of the rash, but is due to the absorption of the poison or toxin.

5. As a rule nursing infants do not contract infectious diseases readily, as the tonsils are small and inactive.

6. The tendency to contract infectious disease would be much lessened if the mouth and tonsils were in a healthy condition.

7. The enlargement of the nodes is more marked in certain infectious diseases than in others. For instance, they are larger in erysipelas, measles and rubella than in scarlet fever and whooping-cough.

8. They resolve more quickly in diphtheria under the influence of anti-toxin than they do in measles and erysipelas.

9. In all infectious diseases (except those of local inoculation) the poison most likely enters the system through the tonsils.

10. Suppuration does not take place in the nodes unless we are dealing with a mixed infection.

When called to see a child suffering from an infectious disease, it is one's duty to examine the other children in the family, who have been exposed, and, if the nodes are found to be enlarged, they too should be isolated immediately, and thus do away with the dangerous custom of billetting children upon friends and relatives, with the inevitable result of spreading the disease broadcast. I am satisfied that in the future the practice of isolating children already suffering from infected nodes will largely do away with epidemics in public schools.

A glance at the mortality tables of all our large cities will show a high death-rate from infectious diseases, and the early recognition of infectious diseases by means of the node involvement would result in these precautions, which would prevent the spread of the disease, thus materially reducing the death-rate from infectious diseases.

* * *

PULSUS PARADOXUS IN PERICARDITIS WITH EFFUSION.

Calvert (*Journal American Medical Association,* April 6, 1907) reports two extremely interesting cases of pericarditis with effusion, and discusses the mechanical basis of the paradoxical pulse, that is, a pulse, which during inspiration becomes feeble or imperceptible. Rigal discusses three conditions in which this type of pulse is met with.

1. Mechanical interference with the large veins and aorta, as in Kussmaul's case. Here the heart is unaffected.

2. Obstructions in the air passage, causing an increased negative intrathoracic pressure, which inhibits the heart's action.

3. Lowered activity of the heart.

Calvert made most careful studies of the cadaver in two cases of pericarditis with effusion, the cadavers being injected with formalin, and allowed to harden, and afterwards transversely sectioned. A careful study of the physical conditions obtained in these cases leads Calvert to the following conclusions:

1. Pericardial effusion produces stenosis of the venae cavae.

2. This stenosis is relatively compensated by a rise in venous pressure.

3. This compensation fails when the pericardial pressure is greater than the venous pressure.

4. Owing to respiratory change in venous pressure the degree of broken compensation varies in inspiration and expiration—greatest in inspiration, least in expiration.

5. The variation in compensation carries varying quantities of blood to right heart (and to general circulation)—least in inspiration, greatest in expiration.

6. The respiratory variation in quantity of blood passing to general circulation is sufficient to explain pulsus paradoxus.

* * *

THE TWENTY-THREE-HOUR TREATMENT.

Northrup (*Archives of Pediatrics*, April, 1907) furnishes a very practical article on the subject of the fresh air treatment of children's diseases. The article offers nothing especially new, but the subject is of such importance to the welfare of children that we append Northrup's conclusions:

1. The twenty-three-hour cure or twenty-three-hour treatment consists in living twenty-three out of the twenty-four hours in the best obtainable cool flowing fresh air.

2. The treatment is especially excellent in convalescence from acute illness, in cases of delicate infants and young children not thriving.

3. The quality of cold or cool flowing fresh air is essential. Cold air may be stale. Air may be oxygenated and free of odors and yet be warm. The air should be flowing freely and cold.

4. Cold fresh flowing air has uniformly certain effects upon young patients. First they sleep. They remain quiet so long as they are in the open air, and sleep most of the time. The quieting effect is well proved. Second, they take more food and assimilate it better.

5. Patients in the open air rarely catch cold, much less often than those kept habitually in warm rooms. Something depends on the nurse, of course, but in a wide experience with different nurses selected by chance, the patients have rarely caught cold. In the whole winter's experience at Sea Breeze no child has developed pneumonia.

NUTRITIONAL DISTURBANCES IN INFANCY DUE TO OVER-FEEDING.

Brennemann (*Journal American Medical Association*, April 20, 1907) furnishes an article of real interest on the nutritional disturbances in infancy due to over-feeding. The article is especially pertinent because of the undeniable fact that there is a tendency in the case of most children, certainly in the middle and upper classes, to be over-fed. He sketches the clinical picture of over-feeding, the restless sleep, the constipated bowel movements with their putty-like consistency, the ammoniacal urine and the general diminution of tone in the tissues. He reports five cases in full, and, after discussing the later effects of over-feeding, comes to the following conclusions:

1. Over-feeding is so prevalent in this country that it is the rule.
2. Over-feeding is second to no other factor in the pathogenesis of infant feeding.
3. Over-feeding presents an unusually recognizable, definite symptom-complex.
4. The percentage method is inadequate to prevent over-feeding, the well-known feeding "schedules for an average healthy infant" of a given age fostering it by recommending excessive amounts; and, moreover, mere percentage leaves undetermined the amount of food the baby gets.
5. To feed rationally and especially to prevent over-feeding it is necessary to know how much food the baby is getting in proportion to its body weight, best expressed in terms of energy quotient.
6. The disturbing element in over-feeding with cow's milk is in the fat.
7. Fat in excessive amounts regularly produces constipation—proteids never do so.
8. It is never necessary to give more fat than proteids of cow's milk.
9. The interval between feedings should be 4 hours.

Books Received.

TUMORS, INNOCENT AND MALIGNANT: THEIR CLINICAL CHARACTERS AND APPROPRIATE TREATMENT. By J. Bland-Sutton, F.R.C.S. Fourth edition. Publishers, W. T. Keener & Co.

JOHNS HOPKINS HOSPITAL REPORTS. Vol. XIII, Studies in Urological Surgery. Vol. XIV, Studies on Hypertrophy and Cancer of the Prostate. Publisher, Johns Hopkins Press. 1906.

PLASTER OF PARIS AND HOW TO USE IT. By Martin W. Ware, M.D. Publisher, Surgery Publishing Co. 1906. $1.

PARAFFIN IN SURGERY. By William H. Luckett, B.S., M.D., and Frank I. Horn, M.D. Publisher, Surgery Publishing Co. 1907. $2.

PRINCIPLES AND APPLICATION OF LOCAL TREATMENT IN DISEASES OF THE SKIN. By L. Duncan Bulkley, A.M., M.D. New York: Rebman Company. Price, $1.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

NOTICE.

AS NOTED in the announcements of the June issue, the semi-annual meeting of the Faculty takes place at, and en route to, the Jamestown Exposition, September 11, 12, 13.

On account of the necessary guarantee to the Steamship Company which must be paid July 24, and other expenses incurred in making arrangements and securing accommodations, you are earnestly requested to send in your names promptly; each name must be accompanied by $8.00 as part payment on the total of $15.00 for the trip, balance to be paid on the day of sailing.

Those wishing to read papers at the scientific meetings will kindly send their names to the Chairman of the Committee.

Those who have already sent in their applications for accommodations on this trip, will please send in the necessary deposit if they have not already done so.

All communications for reservations, and remittances for same, should be addressed to the Chairman of the Committee of Arrangements, G. Milton Linthicum, Professional Building, Balt.

PAID SUBSCRIPTIONS TO THE OSLER TESTIMONIAL FUND.

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MEETINGS OF COUNTY MEDICAL SOCIETIES.

ANNE ARUNDEL COUNTY.

A MEETING of the Anne Arundel County Medical Society was held at the beautiful home of Dr. Thomas H. Brayshaw at Glenburnie Tuesday, June 18, 1907. It was the annual social session of the members of the society, and among those who attended the meeting from Baltimore were Drs. Charles G. Hill, F. J. Kirby, S. T. Earle, A. Lee Ellis, I. R. Trimble, Charles O'Donovan, J. H. Branham, L. M. Allen, John D. Blake, G. M. Linthicum, W. S. Gardner, F. D. Sanger, J. H. Smith, John Neff, J. C. Bloodgood, L. K. Hirshberg, A. M. Shipley, H. C. Davis, H. P. Hynson.

Those from Annapolis were Drs. F. H. Thompson, L. B. Henkel, Jr., S. S. Hepburn, W. H. Hopkins, J. O. Purvis. Others present were Drs. C. R. Winterson, Hanover, Md.; H. B. Gantt, Millersville, Md.; J. S. Billings, Armiger, Md.; S. H. Anderson, Woodwardville, Md.; C. H. Brooks, Brooklyn, Md.; Abraham L. Kaye, Calmar, Iowa.

After luncheon, at which Dr. Brayshaw proved an interesting and delightful host, the meeting was called to order, Dr. H. B. Gantt, President, in the chair. Dr. Charles O'Donovan made the opening address, in which he criticised the members on account of the smallness of their number present, and said he was surprised that the meeting was not better attended.

Papers were read by the following: Drs. J. H. Branham, A. M.

Shipley, J. C. Bloodgood, I. R. Trimble. Short talks were made by Drs. John D. Blake, L. K. Hirshberg and L. M. Allen.

BALTIMORE COUNTY.

The Baltimore County Medical Society met at the Guild House, Towson, Thursday, June 20, 1907. The meeting was well attended and Dr. Charles O'Donovan, President of the Medical and Chirurgical Faculty, addressed the members on the subject of county organization.

Papers were read by Dr. A. D. McConachie on "Essential ear knowledge for the general practitioner," and by Dr. Benjamin Whiteley, President of the Association, on "Relations of the county societies to the State Faculty." The papers were discussed by Drs. R. C. Massenburg, Samuel Theobald, Harry S. Jarrett and L. Gibbons Smart.

An invitation to meet next month at the home of Dr. Smart, in Lutherville, was accepted.

CHARLES COUNTY.

The following officers were elected at the meeting of the Charles County Medical Society, held May 21, 1907:

President: Dr. John T. Digges, Port Tobacco.

Vice-President: Dr. Samuel L. Hannon, La Plata.

Secretary-Treasurer: Dr. Thomas S. Owens, La Plata.

Board of Censors: Drs. Spencer, Munroe and Gough.

Delegate to State Association: Dr. L. C. Carrico. Alternate: Dr. Chappelear.

WORCESTER COUNTY.

Copy of resolutions unanimously adopted by the Worcester County Medical Society, at its regular semi-annual meeting in Snow Hill, Md., May 21, 1907.

Whereas, The question of medical examination fees for old line life insurance companies was brought up in the Worcester County Medical Society, at one of its regular meetings, for the purpose of obtaining the consensus of opinion of its members relative to the reduction of the examination fees by some of the old line companies from Five Dollars ($5.00) to Three Dollars ($3.00); and

Whereas, After due deliberation the conclusion was reached that a fee of less than Five Dollars ($5.00) is not commensurate with the services rendered in making an examination for one of the old line companies, where a urinalysis is required; and

Whereas, In the judgment of the members assembled this step taken by some of the old line companies would tend to lower the standing and character of the work done by the medical departments of these companies, and thereby work an injustice to the policy-holders, and to the examining physician; therefore be it

Resolved, That we the Worcester County Medical Society do

hereby declare our protest against this reduction of the examination fee; and be it further

Resolved, That we pledge ourselves as a society of honorable and professional gentlemen to make no examination for any old line life insurance company, requiring a urinalysis, for a fee less than Five Dollars ($5.00). And where a microscopic examination of sputum or urine is required, the fee shall not be less than Ten Dollars ($10.00); and be it further

Resolved, That a copy of these resolutions be placed on the minutes of the Worcester County Medical Society; a copy be sent to every physician in the County; and also a copy be sent to every old line life insurance company conducting business in the County.

J. S. AYDELOTTE,
President.
R. LEE HALL,
Secretary.

SECTION ON CLINICAL MEDICINE AND SURGERY OF BALTIMORE CITY MEDICAL SOCIETY.

Syphilis of the Central Nervous System; Report of Two Cases.—Dr. Alexius McGlannan.

Syphilis of the nervous system is far from uncommon, and the manysidedness of the disease is shown in the infinite variety of its manifestations.

Lesions of the nervous system occur early and late in congenital and acquired lues, and the so-called para-syphilitic disorders form a large group in any neurological classification.

I shall not attempt to review the literature of the subject nor to consider it in a complete way, but shall merely report two interesting cases. They show wide variety of symptoms and point out in an especial manner the essential benignity of lues and the gratifying results of specific treatment.

The essential features of the general pathology of syphilis is the change in the arteries, with the accompanying round-cell proliferation, and the effect of the peri- and endarteritis on the caliber of the vessel is shown in the nutritional disturbances of the tissues whose blood supply has been altered.

The induration of the chancre is the result of the round-cell infiltration accompanying the arteritis, and all lesions, from the macule of the early secondary stage to the gumma, owe their characteristics to the variations in the arrangement and extent of this change in and around the vessel.

Gumma, the characteristic formation of late lesion, is a mass of granulation tissue which varies, according to its duration, in vascularity. The blood-vessel change causes dry, caseous areas of

central necrosis. Like any other new growth, a gumma produces pressure changes in surrounding tissues.

In syphilis of the nervous system the nerve cells are not directly diseased, but undergo nutritional change from circulatory or pressure disturbances. This is in keeping with the general rule of pathological processes in highly specialized tissue. The ordinary connective-tissue cell bears the brunt of the mischief. The more highly-developed cells, remaining passive, are secondarily altered.

The lesions of the nervous system fall into three groups—I. Gumma; II. Diffuse gummatous infiltration of the meninges; III. Arteritis. In all the groups multiple foci are common, causing a remarkable random association of symptoms. The different types of lesion are often associated, and the clinical picture is complicated by the combination. Thus a cortical gumma may occur with an arteritis of a branch of the middle cerebral artery. The lesions are more often situated on the meninges and on the surface of the brain and cord rather than deep in their structure. The age of the patient does not influence the involvement of the nervous system in syphilis. The nervous system is attacked at extremely variable periods of the disease. The most common time is about three to four years after the primary lesion, but cases are recorded occurring at all times from the early ones developing before the initial lesion has healed to some very late ones, 18 years after the onset of the disease. Hereditary syphilis, with involvement of the nervous system, is rare,[1] but does occur, and the delayed development of the symptoms of hereditary syphilis, observed in lesions of other parts of the body, show the possibility of a late involvement of the nervous system.

Inside the cranium gummata occur primarily in the dura or may extend from the bones of the skull. They vary in size and number, a single gumma being distinguished with difficulty from a tubercle. The large formations produce pressure symptoms, irritation and paralysis of nerves and circulatory obstruction. They may invade the vessel by growth into its wall, and the process may progress to complete obliteration.

Involvement and obliteration of the great sinuses of the cranium occurs. Dames, quoted by White and Martin,[2] reports a case of gumma of the tentorium cerebelli in which all the sinuses bordering on the torcular herophite were obliterated. The gumma is surrounded by an area of brain tissue in which there is increased vascularity, with many new connective-tissue cells. It is obvious that if the process continues until the connective-tissue cells have become fully developed and gone on to fiber formation that the resulting scar will be the cause of irremedial alterations in the brain cells, even though the gumma itself be absorbed as a result of the treatment.

As syphilis does not directly attack nerve cells, gummata of the cord are rare, and when they do occur are most often extensions from the meninges or vertebrae. Occasionally they have been

found in the center of the cord, situated in the course of a blood vessel.

Gummata in the region of the bony canals of exit of spinal and cranial nerves are a frequent cause of paralytic or irritative symptoms. Gumma of the nerve itself is very rare, and when it occurs the lesion is a very late manifestation of the disease. As elsewhere, the ordinary connective tissue is the point of attack, the fibrous sheath, and not the essential nerve tissue being the seat of the gumma. A syphilitic neuritis has been described, but this is a very rare lesion. As a rule, the earlier in the disease a peripheral nerve becomes involved the better the outlook for restoration of function.

The diffuse gummatous infiltration of the meninges involves all the membranes and extends into the brain or cord, causing softening and sclerosis. The condition is most often primary in the pia, and most commonly involves the membranes of the cord and at the base of the brain. The areas of pachymeningitis vary greatly in size and in distribution, but have never been observed to cover the surface of a hemisphere of the brain. The meningitis is most dangerous when the areas are situated in the membranes surrounding the canal of exit of a nerve.

The arteritis is the most important factor in the causation of softening and hemorrhage. Consequently when the disease is limited to an arteritis the probability of development of some permanent lesion is very great. As a result of the arteritis there is a weakening of the wall of the blood vessels that frequently results in miliary aneurisms widely distributed throughout the brain. The diminished caliber of the artery following the inflammatory change causes a lessening of the blood supply to areas of brain and cord, with anemic neurosis. It also gives rise to embolism and thrombosis, all ending in destruction of nerve tissue and its replacement by fibrous scar.

The pathology of the lesions demonstrates that the hope of cure depends on the recognition of the disease in its early stage, in order that treatment may begin during the stage of proliferation before the development of scar tissue or secondary change.

Bevan[3] in his paper on the benignity of syphilis points out the complete curability of the disease under appropriate treatment. Treatment cannot reconstruct specialized cells that have been destroyed, nor can we expect to overcome the results of scar formation by treating the long-changed condition which caused the scar.

Case 1. Luetic arteritis or meningitis, paralysis of seventh nerve, paraplegia, involvement of sphincters. Cure in 41 days.

E. R., white male, age 25, single; initial lesion two and one-half years ago; secondaries light; treated one and one-half years with H_9 and K_1; no complications, except in mouth. These disappeared when some bad teeth were treated by the dentist.

Present illness began about a month before I saw him. Patient had complained of headache, and became more and more stupid, with some occasional fits of delirium, so that his mother accused him of drinking and of drug addiction. When I saw him first he

complained of severe headache, to which he attributed his stupidity and insomnia. The pain was worse at night and made him restless. He had never been unconscious, neither had convulsions nor vomiting, but felt sick enough to remain in bed. Because of my knowledge of his primary attack of syphilis, I at once put him on K_1, but the condition became worse, and he entered St. Agnus' Hospital on December 8, four days later. At the time of his admission to the hospital his condition was as follows: Patient was stupid and listless, complained of headache, was unable to stand or walk. The skin was ashy-gray in color, lips pale, pupils even and active, no ophthalmoplegia, the tongue protruded straight. The right side of the face was paralyzed. The knee jerks and cremasteric reflexes were absent. The thigh muscles were all relaxed, but patient could flex and extend foot and leg and abduct and adduct thigh. The next day the sphincters became paralyzed, so that there was incontinence of urine and feces, and the patient's mental condition was greatly disturbed. Stupor and delirium were marked; he was very restless—so much so that he fell out of bed. Hypodermic doses of mercury were bgun on this day in addition to the iodide by the mouth. The condition of the patient remained serious and about as described for six days, when improvement was noticed. During this time he had 1 c. c. 10 per cent. salicylate of mercury hypodermically every second day, and the K_1 was increased to 60 grains t. i. d. On the sixth day the sphincters regained their power and on the fifteenth day the legs could be moved freely, but the muscles were weak and the patient could not walk well. The facial paralysis gradually cleared up and on the twenty-fourth day had disappeared. From the thirtieth day on the hypodermics were reduced to one a week because of a sore mouth. There was steady improvement in his general condition, and he was discharged on the forty-first day cured, having gained 14 pounds in weight while under treatment.

In this case probably there is an association of different types of lesions. Vascular disease could cause the symptoms, or meningitis might explain them, or, again, the condition might be central of a nature resembling polio-myelitis. The motor paralysis without loss of sensation is in favor of a central lesion rather than a pressure on nerve roots. The intense headache favors a meningitis. Stupor is usual in all varieties of cerebral syphilis, and is often a prodromal sign. The involvement of the sphincters is common in all severe motor paraplegias of hectic origin.

The course of the disease in this patient should be compared with Hutchinson's Commentaries, 55 to 58.

Case 2. Gumma in the region of the cavernous sinus; probably late hereditary disease; trifacial pain, facial paralysis, ptosis, unilateral exophthalmus.

Patient is a married woman, age 35, who was sent to me for a Gasserian ganglion operation because of the intense trigeminal pain. She gives no history of a primary lesion nor of any conditions indicating secondary lues. In childhood she had ulcers of

both shins, the extensive scars of which remain. She has been pregnant four times and has had four miscarriages.

Patient complains of intense pain in the fifth nerve areas on the right side. All branches of the nerve are involved, and all the teeth in the lower jaw on the right side have been extracted in a vain endeavor to relieve the pain. This has been so severe that morphia has been given for its relief. There is right-sided unilateral exophthalmus, facial paralysis and ptosis. The pupils are normal, vision and hearing normal.

Potassium iodide was given in increasing doses for 10 days, but without any result. The patient was then admitted to the City Hospital, in the service of Dr. Bevan, to whom I am indebted for the privilege of treating her and of reporting her case.

On admission the patient's condition was as indicated, and she was at once given mercury hypodermically, and the iodide rapidly pushed to 60 grains three times a day. Improvement commenced at once and continued until at the end of 24 days she left the hospital cured.

Three months later: She has had no more pain; the exophthalmus and ptosis have disappeared; the face muscles are active. She was perfectly well.

This case is of much interest because of the possibility of its being a late congenital manifestation. The combination of symptoms is apparently unique. The involvement of the seventh nerve in both cases should be noted. Hutchinson[5] notes the relative immunity of the seventh nerve in syphilis, but other authorities do not agree with him. White and Martin calls attention to the tendency of the nerve to be affected early in the disease.

The necessity of mercury in treatment of late lesions is shown in both cases. Neither patient showed any improvement on the iodide alone, and both began to improve after the hypodermic injections of mercury. This method of administration seems to us the best in all cases when the action of the drug is urgently demanded. The pain and discomfort of the deep injection into the buttock, so objectionable to the ambulant patient, is much diminished when the patient is in bed.

The 10 per cent. suspension of salicylate of mercury in either paraffin or a fat oil may be used. Personally I prefer the fat, because I believe it is less likely to cause local disturbance.[6]

REFERENCES.

[1]Fairbanks: "Cerebral Syphilis in Childhood."
[2]*Journal of the American Medical Association,* March 9, 1907.
[3]White and Martin: "Genito-Urinary Diseases and Syphilis."
[4]Hutchinson: "Syphilis."
[5]Hutchinson: "Syphilis Commentary," 79.
[6]McGlannan: Review in Surgery, MARYLAND MEDICAL JOURNAL, December, 1906.

SUPPLEMENTARY REPORTS TO PRESIDENT'S ADDRESS, APRIL 23, 1907.

COMMITTEE TO CONFER WITH LAY PRESS.

Dr. R. B. Warfield.

Mr. President—The Lay Press Committee for the first year of its existence has little to report in the way of achievement.

Shortly after its organization, as an initial effort, identical letters were sent to the managing editors of the three foremost newspapers in Baltimore, announcing, in effect, that such a committee had been appointed and begging the interest and support of the editors toward a demonstration and development of its usefulness.

The letters called attention to the growing activity of the united profession in the effort to enlighten and instruct the people generally on medical matters of public importance, and stated that it seemed desirable that we should be able, more or less officially as the State Society, to give voice to the people through the press.

That, besides, we believed if the newspapers desiring information on any medical topic were in the position of making use of the committee toward securing authoritative interviews from sources selected by the committee, improper or misleading information would be less frequently published, and the people, the press and the profession be all benefited.

Later on we attempted by personal interview to interest the city editors in our undertaking, and again offered our active co-operation in supplying the public with news of medical sort. We suggested that with this relationship established we would, on occasion, be in a position to give to the newspapers items of medical interest without solicitation.

It may be said that the press as approached by us has received our suggestions politely but without enthusiasm, and so far but little use has been made of the committee.

That there is reason for this somewhat negative attitude may be illustrated by the fact that in a specific instance where a city editor came directly to us asking an interview with someone of our selection concerning a prevailing disorder, the doctor selected refused to grant the interview, on the ground of not wanting to appear in print. Obviously, unless the committee is supported by the members of the Faculty, we cannot hope for much progress. City editors and reporters are practical men with limited time, and we must deliver our copy or interview cheerfully and promptly, or they will seek other sources. Of course, the editor and the doctor do not see the situation from the same viewpoint, and in many cases they are not likely to. The fear of publicity on the doctor's part, the ethical offense as so often expressed, the editor probably regards as archaic and silly, and if there is any other reason why information sought after should not be given, he wants to be told it and not virtually be shown the door.

We should get used to the fact that, as things are, the name of the doctor interviewed must as a rule appear. While official utterance of the Faculty would probably always be printed, anonymous communications are, for the most part, unsatisfactory; nor would a single interview in identical language for all the papers be considered adequate.

It is interesting to know how the editors regard us in our public relation. One city editor told us frankly that the doctors were, of all classes, the most unsatisfactory people to deal with; that their attitude toward the press was one of mistrust; that they avoided, without reason, giving to the press matters that clearly concerned the public, and that for these reasons, so far as his paper was concerned, information on medical subjects was, as a rule, only sought from those in official place, who could and who would speak without evasion and fairly, namely, the Commissioner of Health and the Secretary of the State Board of Health.

Up to this time we have not attempted to discuss officially with the press the larger evils chiefly pertaining to the advertising columns, the exploitation of charlatanisms and of the multitudinous nostrums, more or less harmful, which depend for their existence on the publicity thus given.

The remedy for these great wrongs lies in the education and enlightenment of the people, and the press, potent for harm, could be made an equally powerful instrument for good. Perhaps in the schools instruction should be given that the coming generations may be informed. The dissection already made by a few courageous journals of certain proprietary preparations vaunted as health-giving blessings and used as panaceas in thousands of households, promises great good. The pure-food and drug law is a long step in the right direction. We are in the morning of a better day, and with public opinion aroused the press will speak effectively for the good of the people.

It is a question how far the medical profession as such can forward this contest. It is likely that our work should be supplemental and accessory rather than initiative. In the meantime, we have our own errors to correct, our own position to review. It has been whispered that the doctor himself is often at fault, and, so far from being a leader, is sometimes only a tardy follower along lines of progress. It is true that there is a peculiar lack of unity and cohesion in our ranks. We are too self-centered; there is "too much ego in our cosmos!" Our work is, for the most part, individual and with the individual, and we lose the practical advantage of actual co-operation.

In our relations with the people, while most of the aspects of medicine can only be profitably discussed among the doctors themselves, and bearing in mind that the people could easily be given a pernicious instruction, because ineffective and misunderstood, still, speaking broadly, we should take the people into our confidence, and if we speak at all, should speak clearly and without cant and without mysticism. Unfortunately, we doctors are still too often

enveloped with the robe of Paracelsus, and are, perhaps unconsciously, hampered by the traditions of the ages dominated by darkness rather than light.

The doctor of the right sort neither needs nor desires newspaper notoriety, but he should not be frightened or criticised if for good reason his name appears in print. The fear of giving offense to his brethren and the respect for so-called medical ethics has prevented many times pertinent expression on matters of great interest to the people. Nevertheless, so far as possible, we should sink the individual in an effort to advance the united profession. What could not be accomplished in any public movement by the great body of doctors acting as a unit? And in this community we should strive as individuals to make clearer and more effective the voice of our own State Faculty, the profession as organized in Maryland.

In our relations with the press we will get what we bring. If we have a message for the people, the press will deliver it. But we must speak fairly and freely and with substance, having something to say.

COMMITTEE ON DISPENSARY ABUSE.

Dr. W. S. Thayer.

The President of the Medical and Chirurgical Faculty of Maryland last year appointed a committee to "investigate the extent and possibility of correcting the dispensary evil," a matter which was referred to by the retiring President, Dr. Earle. This committee, after consultation, impressed by the fact that "the dispensary evil" is regarded by different individuals from widely different points of view, decided that it might be of interest, as a preliminary step, to send out a letter to a number of physicians in this city and to a few individuals interested in this subject in other parts of the country, asking their opinion as to what constitute the main dispensary abuses. The answers are not uninteresting, showing as they do wide divergence of opinion.

The following are the main points brought out by this investigation:

(1) Some physicians express the opinion that the chief dispensary evil consists in the abuse of charity by patients able to pay a proper fee for medical attention; and it is the *general* belief that the number of such patients is considerable.

One observer points out the fact that it is common in one of the dispensaries with which he is associated for individuals, such as street-car employes, who may be detected by their uniform, to apply for free treatment—men who must be earning a fair salary.

On the other hand, a man of large experience, occupied for years in supervising and investigating the fitness of patients applying for treatment at a large dispensary, after expressing the following rather radical sentiments, "Doctors seem to me to be eminently

unable to judge of the financial standing of people," calls attention to the fact that, owing to the common habit in this country of living up to the limit of one's means, it is often true that those who might from their occupation be expected to be in a condition to pay, are really, owing to temporary misfortune or loss of work, in a condition of genuine want. Moreover, it is common for women especially to put on their best clothes when visiting a dispensary, thus giving rise to false impressions, while these garments may be the last vestiges of a vanished prosperity.

He further asserts that many physicians have confessed to him that dispensaries are "quite a relief" to them, inasmuch as their patients, "when unable to pay, go to dispensaries, and when in funds send for their attending physician again." He ends with this interesting observation: "The fact of it is, when the average American has money he spends it, and becomes a pauper under any misfortune which is lasting."

(2) Some practitioners of medicine, also, feel that the prevailing idea as to the abuse of dispensaries by individuals able to pay for the services of a physician are considerably exaggerated. One physician, a young man without independent means, depending entirely upon practice for his support, a man who has had considerable experience in work among the poor, expresses the following opinion: "This is a greatly exaggerated worry, and its agitation, due mainly to certain physicians whose practice, or, rather, income, is as yet very small. That there are persons who abuse the charity must be true, but they include patient and doctor, and of the two I think the latter is the greater offender, for the dispensary is often used to obtain a cheap consultation or to allay the fears of a dissatisfied chronic or neurasthenic, and thus prevent his drifting away." In other words, the physician is here regarded as abusing the dispensary by exacting free consultations.

(3) Another physician, however, complains that one of the chief dispensary evils is the very fact that the out-patient departments of hospitals are so ready to afford this assistance, asserting: "Another condition that exists, and which is an injustice to both physician and dispensary, is that of taking a patient to the dispensary for the confirmation or contradiction of diagnosis." He observes that, while he is unaware as to what patients tell the dispensary officers, the frequency with which the abuse occurs would suggest that it was an easy matter to obtain free treatment when the patient is perfectly able to pay.

(4) One physician thinks that a serious abuse consists in the advertisement which the senior members of some hospital staffs obtain through the printing of their names on the dispensary cards which are carried by all patients to their homes. The desire to obtain such advertisement often prevents proper discrimination among the patients admitted to the dispensary, inasmuch as the distribution of these cards in the homes of those able to pay is naturally a personal, private benefit to the members of the staff of the hospital.

(5) Others object to the practice which prevails in some dispensaries of occasionally collecting fees from individuals who can pay or who actually offer remuneration. A dispensary, they assert, should be a purely charitable institution. The collection of fees is manifestly unjust to the practicing physician.

(6) Several observers point out as a grave evil the existence of small dispensaries which charge a moderate sum, from 10 to 25 cents, for services rendered. These institutions are objected to on the ground that (*a*) they do an injustice to the physicians of the neighborhood, and (*b*) because in such concerns the arrangements and facilities do not allow proper attention to the patient, the institution existing as a purely money-making affair.

(7) Another practitioner who has devoted much time to the study of dispensary problems is strongly of the opinion that the dispensary should be a purely charitable institution, in which the material should be used for teaching purposes and scientific observation. "The dispensary should be a collection of specialists of high standing, with laboratories, a hospital and such equipment as to enable them to make careful scientific observation. The physicians at present in the dispensaries are usually young men of no experience, whose fees many of the patients could pay. Were specialists in charge, the institution would then offer to the patients opportunities which would otherwise be wholly beyond their reach." The dispensary "which attempts to partially defray expenses by charging a fee," as well as that "which is run for commercial purposes or as a feeder to the practice of attending physicians," is unworthy of existence.

(8) One gentleman, not a physician, a well-known student of social problems, asserts that to his mind "the most important thing to be avoided in dispensaries, as in any form of help that is free, is the weakening of the self-reliance of the poorer classes of people. My experience," says he, "is that most people among the laboring class who are self-supporting prefer to pay for what they get in sickness as well as in health. If they use the dispensaries it is because they cannot afford to pay the doctors' fees for an extended time or for serious operations. This feeling of independenec ought to be encouraged in every possible way. Another objection to free help is that it tends to lower wages. If people learn to depend on free medical aid, they are willing to accept correspondingly lower wages than they would if they had to make provision against sickness.

"Sick-benefit societies and societies which enable a doctor at a fixed salary to attend any and all of their members whenever need arises seem to be better for the poor from the moral point of view than free dispensaries. They encourage thrift. * * *

"I can see the other side of the dispensary question. The advantages to medical science are great. The patient gives a certain *quid pro quo* for his treatment in giving himself as material for observation by students, and I must confess that I have not seen any great moral harm done to individuals by the dispensaries. I

have, however, seen physical harm done by careless treatment, and there can be no question as to the great importance of bringing the dispensaries up to a high standard of medical work. They should not be allowed to undertake to handle more cases than can be handled thoroughly; they should only be in charge of high-grade physicians."

(9) One physician asserts: "The worst and practically the *only* 'dispensary abuse' that I have knowledge of is the one where persons are charged for the prescription (10 cents, I think, is the fee where this rule holds). This has prostituted more 'paying' patients into 'beats' than anything I have encountered in 25 years of general practice. I could recite you many cases where people worth several thousand dollars, and paying everybody else, apparently, but a doctor, use dispeensaries, saving their consciences by this 10-cent fee, and would indignantly deny being objects of charity. My opinion, therefore, is that there is but *one* abuse worthy of the name, viz., charging a fee for medicine. Make it charity pure and simple, and you at once do away with all abuse, as far as it affects the general practitioner at least."

(10) Finally, one distinguished medical man from another city who has given considerable attention to social problems connected with dispensary work, writes: "My views on dispensary abuse have never been winnowed and tried out by any careful investigation of the subject, but so far I think the chief dispensary abuses are:

"1. The abuse of patients by careless doctors and externes.

"2. The abuse of opportunities by careless doctors and externes.

"That any great harm comes from the free treatment of folks who can pay I doubt. The physicians to whom they would otherwise go are usually 'N. G.,' and from the point of view

"(1) Of health,

"(2) Of character,

"(3) Of instruction in hygiene,

I believe the patient gets more by coming to a free dispensary, even when he can pay. I doubt if his character suffers in the process, and as for the loss of money to the doctors, I do not regret it. I think it more than made good—from the point of view of the public good, which is the only point of view that we can take—by the physical, psychical and educational good done by the dispensary, even for rich patients. I do not believe you can surely weed out the rich, either, by any spotting process."

These different views appear to us to contain much food for thought. That evils do exist in connection with our present system of free dispensaries is unquestioned, but a moment's consideration of the views which I have just quoted cannot fail to impress one with a realization that the extent of these evils and their relative importance as compared with the manifest benefits inherent in the system are debatable questions. The regulation of dispensary abuses is a very wide problem, one which is obviously not to be settled by any simple measure. It is, further, a problem

which clearly cannot and should not be approached by physicians alone. It is, moreover, a problem which affects especially the greater centers of population, the cities rather than the State in general.

Your committee, therefore, feels that it is a matter which might much better be taken up, if it is to be taken up, by the city medical societies in conjunction with the Charity Organization Society and other bodies and individuals who have given special study to social problems. One must realize, as stated by our President, that improvement in existing conditions can be brought about only through co-operation, but such co-operation must be not only among the medical profession, but among all citizens officially and unofficially occupied with questions of social economy, as well as among public-spirited citizens in general.

REPORT OF THE STATE BOARD OF MEDICAL EXAMINERS.

Included in this report is the summary of results of the examinations held by the Board of Medical Examiners, June and December, 1906, together with the questions used in these examinations. This summary was published in the September, 1906, and March, 1907, issues of the Maryland Medical Journal, and your attention is respectfully directed to these publications that you may make such investigation thereof as your interest in the subject may prompt. You will find in this summary the number of participants, school and year of graduation, rating in each branch examined with the average attained, 75 per cent. being required to secure license to register as physician and surgeon. Under the provisions of the law those coming before the Board for re-examination are required to make a rating of 75 per cent in each branch in which they have heretofore failed. It has been the purpose of your Board to make the publication of the "results of examination" so full that they will present the actual work, so far as examinations are concerned. There are, however, other features constantly appearing under the operation of the law regulating Medical Practice which could not be presented as examination work, and to some of these your attention is respectfully invited.

It may be safely declared, that in every State legislation has been enacted providing for the regulation of Medical Practice. These laws necessarily vary according to the individual views of law makers, moulded doubtless by the numerous and frequently, undiscoverable influences surrounding law-making bodies. But independent however, of this phase of the subject, it must be admitted that they are in the main, practical, effective and salutary. All law is intended to be helpful. It springs from desire inborn in man, for improvement, for advancement, for uplifting and the establishment of right for the sake of right coupled with justice.

And so these laws throughout the various States have their

origin in the spirit and purpose of the medical profession to uplift and better qualify itself for the performance of its great work, the accomplishment of which transcends all other human activities.

A higher standard of professional character and attainment is the keynote and cornerstone of all medical legislation. It carries with it nothing of selfishness, nothing of pelf, prejudice, or partisanship,—nothing of discrimination or favoritism. Its only aim and purpose is that the medical profession becomes more learned, more honored and more effective in the treatment of disease and the alleviation of human suffering. This is the whole purpose of the law. It has been in operation during the past ten or fifteen years. In some States, however, not so long; but the period just named indicates, with sufficient accuracy, the time during which the influence and purpose of legislation of this character should have in some degree impressed the profession and the public. What are the results? In the matter of examinations, do they indicate an advance in scholarly attainment, a higher and better equipment of the applicant? The ratings made, and which determine licensure, are secured by as careful, unbiased and intelligent sifting of the material presented as may be possible. Whether or not this material, which is to constitute the future profession, the membership of this faculty, and fill the honorable and responsible places adorned by those who have gone, is improving, is measuring up to the contemplated standard, should receive our most careful consideration. In our individual life, professional as well as lay, we are examples and should so walk, but those in the role of preceptor or instructor, carry a weightier responsibility.

To enforce this thought and to assist in reaching a conclusion we have analyzed the results of the examinations during the past five years, placing in a class to itself those taking the examinations the first time. You will recall, that under our law, all those failing are entitled to re-examination, and you will note in the published results they have been so designated. While many of them have been finally successful and licensed, it would not be just to include them in an analysis to determine the proportion of successful examinations, as in the primary examinations they were included among the failures.

In 1902 there were 109 primary examinations, of which 73 passed and 36 failed, the percentage of those passing being 66 per cent.

In 1903 there were 154 primary examinations, of which 102 passed and 52 failed, the percentage of those passing being 66 per cent.

In 1904 there were 125 primary examinations, of which 96 passed and 29 failed, the percentage of those passing being 76 per cent.

In 1905 there were 128 primary examinations, of which 89 passed and 39 failed, the percentage of those passing being 69 per cent.

In 1906 there were 114 primary examinations, of which 90

passed and 24 failed, the percentage of those passing being 79 per cent.

To make these deductions of any value, we must assume that during the period the questions submitted have been practically the same grade, and that the examiners have not varied in their appreciation of the value of questions and answers and have so rated.

We therefore regard this analysis as indicating that during the last three years there has been a better selection of the material admitted as matriculants to the Medical Colleges, and that the quality of instruction has been improved. In other words, the results of the examinations during the past three years indicate that the men entering the medical colleges have had better preliminary education, and that during their medical course they have had better instruction than those examined in previous years. Diligence in study, close attention to the details of duty, combined with intellectuality, will necessarily bring success to the possessor of these qualities. This combination however, is exceptional. Enraptured by the thought that social standing, financial success or a comparatively easy life, are secured by membership in the medical profession—a heterogeneous multitude seeks admission to the medical colleges throughout the land. To the mass of this multitude entering upon the study of medicine, unprepared and unsuited, without preliminary education or habits of thought and investigation, there can come nothing but disappointment, pecuniary loss, failure. Many a letter comes to the Secretary when the unfortunate applicant has found that he has failed in his examination, bewailing his fate, and wildly clamoring that help—absolutely impossible and unavailable, be given him. The scanty fund with which the college course was undertaken has been consumed, and the future is most desolate. This misfortune of the individual soon becomes, through his failure and impecuniosity the picture of the noblest profession disgraced by the abortionist and the self-advertised curers of Male and Female Weaknesses. Can it be denied that much of this wretched lowering of professional character could be avoided if this multitude had been sifted by the requirements of a proper preliminary academic training by those assuming the responsibility of medical instruction. While the analysis referred to suggests that there is a steady advance in the quality of the material coming before the Board, permit us, in justification of what we have said, and to emphasize the necessity for this better training, to present some extracts from answers to some of the questions used in examinations during the past year.

ANATOMY.

Question:—"Give origin and nerve supply of the following muscles—Biceps, Pterygoids, Sartorius, Gastrocnemius?"

Answer:—"Biceps arise by three heads, namely, from the Spine of the Scapula, middle third of Clavicle and head of the Humerus."

Question:—"Name and give location of the ductless glands?"

Answer:—"Ductless glands are found in the Spleen."

Answer:—The ductless glands are submaxillary, sublingual, parotid."

Question:—"What structures pass (a) through the jugular foramen; (b) through the foramen magnum?"

Answer:—"The thoracic aorta and pneumogastric nerve are said to pass through the foramen magnum.

SURGERY.

Question:—Acute Glaucoma—define, describe and give cause and treatment?"

Answer:—Acute Glaucoma is a cancer of the tongue, appears as an ulcer with somewhat raised edges; the center presenting the appearance of little papillae with thread-like veins branching from the ulcer."

Answer:—"Acute Glaucoma is an acute inflammation of the eye, characterized by excessive growth of tissue of a superfluous nature. Treatment—by incision of knife."

Answer: "Acute Glaucoma is a corneal ulcer situated on the cornea."

Question:—"Describe the fracture commonly designated (a) Potts fracture, (b) Colles Fracture, give treatment of each?"

Answer:—Potts fracture is a fracture of the lower end of the fibula, dislocation of the Radius and fracture of the interial maleolus associated with the stretching of the lateral ligaments."

Answer:—"Potts fracture is a fracture of the lower end of the Radius, the lower fragments being displaced backward and the ascend of the styloid process is so crushing that its articular surface looked downward and backward.

PHYSIOLOGY.

Question:—Describe the phenomena and give some of the theories of sleep?"

Answer:—"Sleep is a state of affairs which occurs generally at night time, when you are not aware of what is going on around."

Answer:—"In sleep we pass into a period of rest, and should have eight hours of rest, but I have only had four for a number of years, simply preparing for this time."

Answer:—"The cause of sleep is always the result of over work."

Answer:—"Sleep is the relaxed condition of the body in general and the spinal cord in special."

Question:—"What is the coagulation of the blood? What is intra-vascular clotting? How may it be caused and why does it not take place under ordinary circumstances?"

Answer:—The coagulation of the blood is due to one being exposed to extreme cold or to sudden and violent fright."

Answer:—"Coagulation is caused by indigestion or some foreign substance getting into the blood vessels and is hastened by being overheated, and can be retarded by cooling on ice, agitation, addition of glycerine, &c."

Question:—"Describe the physiological function of the Kidneys?"

Answer:—"The Kidneys are glands that pick up the hipuric acid and seporates the uriates."

Answer.—"To secrete urea and have a hand in helping the liver to store up sugar for future use."

These selections will suffice. Do they not prove that these men should have been subjected to examination as to preliminary education, primary, if you are pleased so to designate it, before taking up the study of medicine. And do not these answers further indicate that it was as easy for these individuals to pass from an Institution of learning as it was to enter.

For the conduct of the examinations your Board has been obliged to formulate a set of rules which were generally developed by experiences proving their necessity. There are, of course, many honorable participants, who would scorn to take advantage of the privileges accorded or violate the confidence reposed in them, but being obliged to treat all alike, everyone is under surveillance. The man devoid of honor has dragged to his own level those who would spurn his methods. Rule 5 says that "a candidate shall not have books or helps of any kind, and that any candidate violating this rule shall be barred from that particular examination." Under Rule 6, the following pledge is required: I..... now at the close of this examination, declare that prior to these examinations I had no knowledge of the questions to be proposed and have neither given nor received explanations or other aid in answering any of them."

Signed.....

This pledge is Signed and delivered to the Secretary at the close of the examination. A copy of the rules for conduct of the examination is supplied with every blank application, so that the applicant has abundant time and opportunity to familiarize himself therewith. The futility of relying upon the honor of those taking the examination has been long since demonstrated, and it has been our practice to have persons present during these examinations to closely watch the participants to deter and detect violation of these rules. It is surprising to note the ingenuity manifested in the efforts to secure assistance. Favorite methods are pages taken from small compends, evidently published for the special purpose of affording facilities for cheating at an examination held by instructor or Board of Examiners. A small folded page closely written and covering the salient points or topics of a subject is another method. In the December 1906 examination each of these methods was in use, one in Anatomy, the other in Pathology. The culprit was detected, publicly exposed and summarily dismissed. When the class reassembled the President called attention to the unfortunate and regretful occurrence and assuring those present of the Board's desire to place all upon a plane of honor and trustworthiness, appealed to them to so act. The response to this attitude of the Board and the call of its President was signalized by

the detection of a member using a leaf from a compend, slipping it from his pocket and holding it in the palm of his left hand, when he supposed he was not under observation. He was likewise exposed and promptly dismissed. Consider for a moment what this behavior meant for the examiner, and let this extract from a letter addressed to the Secretary tell the feelings of the culprit. "I am thoroughly repentant and positively determined to be strictly upright in my future career, for this incident has indeed been a great sorrow, and a great lesson to me. I sincerely trust and humbly request of you that you will not publish in your report in the Maryland Medical Journal the name of the School I represent for two reasons.

First.—For the sake of the honor and reputation of the University.

Second.—Because the Faculty would be inclined to take the matter up and it might mean my expulsion.

While the Board may be righteously indignant, I do not believe there is one who would wish to see such an outcome. I shall mend my way with all the ardor I can command, and I trust that you will at least honor my good intentions and favor me by maintaining as much privacy as possible in this matter. Will you help me to that extent to live this down and develop a future honorable career.

Most respectfully yours,

Pathetic, penitent and a lesson! The Board's wish was to do as requested, but the publication is the record and under the law the register must show the disposition of every case. It was therefore impossible to comply with the request. After this presentation, no apology or explanation will be asked of your Board for placing watchers upon those participating in these examinations. With the number in the Summer examinations ranging from 150 to 175, it is difficult if not impossible to keep every one under close surveillance and prevent the cheat from getting in his work. But these examinations are held for the distinct purpose of ascertaining by legally prescribed methods fairly and impartially who shall receive a license to practice medicine and surgery. This information cannot be secured as contemplated if those participating can submit answers framed through fraud and chicanery, and it is the purpose of your Board here avowed to use every means to suppress the cheat, and if detected, expel him. It is far better that one apparently not so capable but honest, and answering of his own knowledge should pass the Board and be licensed, for he will learn and can be trusted. He will be a safe guardian for the sacred professional relations which often exist between patient and physician. But the man who cheats his way through his examinations into his profession, is starting with a code of honor which will make him unethical with his brothers and untrustworthy with his patients.

The questions used are published with the summary. In fram-

ing them honest effort is made that they should be comprehensive, up to date and above all, fair. Our desire is not to embarrass, but to ascertain the real capabilities of these aspirants for license. That they should receive approval from all is not to be expected, but we have presented the motives and purposes underlying your representatives in the great work of determining licensure and are therefore assured that the sentiments herein expressed will receive your approval.

This paper has grown to proportions not desired, yet your indulgence is asked that you may be informed that in the difficult and vexatious work attending the prosecution of illegal practitioners, much has been accomplished during the past year. In Allegany County a persistent and defiant violator of the law, strong financially, and assisted by powerful personal influences was successfully prosecuted and a fine of $100 imposed. We are informed that an appeal will be taken to contest the constitutionality of the law. Our desire is great that this may be done, so that the standing of this law may be determined from every standpoint. You are aware that in a case carried to the highest Court several years since, the constitutionality of the law was then affirmed, but if there is any provision not enforceable, it is most desirable that it should be made known; hence our welcome of any appeal.

In Washington County a drug vendor, who played the role of physician was convicted and given 30 days in jail. In Baltimore City a much improved condition exists. Many vexatious difficulties are here encountered in the attempt to prosecute the illegal practitioners. Time will not permit their enumeration; nor is it necessary, as you are more or less familiar with conditions. Through individual endeavor, coupled with the effort and influence of the local medical organization, the importance of the enforcement of the law regulating medical practice has been so impressed upon the authorities, that positive action looking to prosecution of many illegal practitioners is under way. Indictments have been found against eleven and they are awaiting trial. Four more cases were sent to the Grand Jury upon the date of this writing. If conviction is not secured in these trials, the offenders will again be presented, and with the weak points eliminated, prosecution will be conducted to a successful issue.

We have endeavored to present to you as best we can, what is being done in the matter of examinations, that the standard of professional attainment may be advanced. We have shown that the percentage of success in these examinations has improved through selection of material and better instruction. We have unmistakably declared that the license to register shall not be secured by open or concealed fraud, if in the power of the Board of Examiners to prevent. In the equally important and yet more difficult task, of bringing to the bar of justice those guilty of defying and violating this law to which you have given your approval, may we not receive your constant, vigorous and all-powerful support.

REPORT OF J. McP. SCOTT, TREASURER BOARD OF MEDICAL EXAMINERS OF MARYLAND, OF RECEIPTS AND EXPENDITURES SINCE REPORT OF APRIL, 1906.

HAGERSTOWN, MD., April 16, 1907.

1906. RECEIPTS.		
April 16, To Cash Balance, as per Report	582 23	
1907.		
April 18, Fees from Licenses, Permits and Transfers	3,745 00	
Total Receipts		$4,327 23
1906. DISBURSEMENTS.		
April 19, U. P. Hackney, returned fee	15 00	
May 8, W. M. Dabney, Exam	90 00	
May 8, Mary F. Shaneberger, Steng	5 30	
May 10, Ira W. Hays, printing report 1906	69 70	
May 17, Hagerstown Bookbinding and Printing Co	2 75	
June 16, Hagerstown Bookbinding and Printing Co	6 50	
June 16, A. S. Abell Co., Adv. June Examination	11 34	
June 16, C. C. Fulton & Co., Adv. June Examination	9 60	
June 16, Evening News Pub. Co., Adv. June Examination	9 96	
June 25, J. McP. Scott, Secy.-Treas., Salary, including office rent and Typewriter, to June, 1906	500 00	
June 25, J. B. Emory, services at Examination	15 00	
June 25, H. A. Stump, Jr., services at Examination	12 00	
June 25, R. J. Turner, moving tables	10 00	
June 25, Fred. Schneider, Janitor, Examination	5 00	
June 25, Amer. Acad. of Medicine, subscription to Bulletin	3 00	
June 25, Chas. S. Cochrane, returned fee	15 00	
June 25, Jas. W. Bangert, Rent Lehmann Hall, June, 1906, Examination	65 50	
June 27, D. H. Warren, returned fee	15 00	
June 27, D. M. Henderson, Stat. supplies for June, 1906, Exam	32 62	
June 30, A. H. Strobel, returned fee for recognition of Ohio license	50 00	
July 2, H. K. Startzman, Postmaster	2 00	
July 3, J. B. Emory, services for examination	5 00	
July 11, M. E. Fort, mimeograph work	20 00	
July 11, Hammond Typewriter Co., supplies, June, 1906, Exam	7 05	
July 17, H. K. Startzman, Postmaster	2 63	
July 17, Adams Express Co	2 75	
July 23, W. M. Dabney, Examiner	71 70	
Aug. 1, Edwin J. Dirickson, Examiner	125 56	
Aug. 1, Robert J. Green, returned fee	15 00	
Sept. 22, W. G. Mac Nevin, returned fee	15 00	
Oct. 6, John B. Deming, Esq., on acct. of salary as Attorney	100 00	
Oct. 8, H. W. Cole, Jr., returned fee	15 00	
Nov. 9, Hagerstown Bookbinding and Printing Co	10 75	
Nov. 26, Evening News Pub. Co., Adv. Dec. Exam	4 52	
Nov. 9, C. C. Fulton Co., Adv. Dec. Exm	4 73	
Dec. 17, Smith, West & Lyon, Detective work	11 15	
Dec. 19, A. S. Abell Co., Adv. Dec. Exam	5 25	
Dec. 20, M. E. Fort, Mimeograph work	20 00	
Dec. 20, Lucas Bros., Typewriter material	2 50	
Dec. 20, Gustav Caution, Janitor	5 00	
Dec. 20, Hammond Typewriter Co., supplies	2 50	
Dec. 21, Chas. H. Martin & Co., printing	9 00	
1907.		
Jan. 5, J. M. Henderson, stat. supplies Dec., 1906 Exam	8 48	
Jan. 11, B. W. Goldsborough, Examiner	109 00	
Jan. 11, F. W. Janney, services Dec., 1906, Exam	20 00	
Jan. 11, Herbert Harlan, payt. to Robert Turner for moving tables	6 00	
Jan. 15, F. B. Smith, Examiner	129 50	
Jan. 17, Edwin J. Dirickson, Examiner	133 06	
Jan. 18, Herbert Harlan, Examiner	205 39	
Jan. 23, Ferd. L. Benz, returned fee for recognition of Nebraska license	25 00	
Jan. 26, Clay M. Easter, returned fee	15 00	
Jan. 26, John Rurah, Secy., Rent of Hall	40 00	
Feb. 12, W. M. Dabney, Examiner	60 00	
Feb. 19, Louis A. Griffith, Examiner	131 06	
Feb. 27, Harry M. Wegefarth, returned fee	15 00	
Mar. 2, B. D. Harrison, Secy., Membership fee in American Confd. of Reciprocating and Licensing Boards	10 00	
Mar. 19, F. D. Mudd, Clk. Chas. Co. list of Reg. Phys	1 00	
Mar. 19, Geo. W. Dowell, Clk. Calvert Co. list of Reg. Phys	1 00	
Mar. 19, Max Ways, Clk. C. C. Balto. City, list of Reg. Phys	2 50	
Mar. 19, J. McP. Scott, Per Diem, R. R. Fare and Hotel exp	249 65	
Mar. 30, Hagerstown Bookbinding and Printing Co	18 25	
April 3, J. A. Stevens, Examiner	140 00	
April 10, Md. Med. Journal Co., Electroplates	15 70	
April 13, J. McP. Scott, cash paid out for Telegrams, Expressage, Postage and Notary Fees	42 12	
April 13, W. M. Dabney, examination of papers	18 40	
April 13, J. A. Stevens, examination of papers	15 30	
Total Expenditures	$2,811 76	
By Balance to close account	1,515 47	$4,327 23
1907.	4,327 23	4,327 23
April 13, By Cash Balance	$1,515 47	

Society Reports.

THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY.

MEETING HELD MARCH 4, 1907—DR. BARKER IN THE CHAIR.

Primary Foci of Infection in Metastatic Arthritis—Dr. Barker. By a metastatic infection is meant an infection secondary to a primary focus of infection and in a part not in the immediate neighborhood of the primary focus. The newer studies of the arthritides make it clear that a large percentage of the cases of arthritis are metastatic in origin. The portal of infection can nearly always be found if carefully sought for. We use the term cryptogenetic infection when speaking of these cases in which no primary focus can be found. It is tolerably clear that the chronic infectious cases of arthritis are due to metastatic infection. There are, however, acute and chronic cases of toxemic arthritis, *e. g.,* gout in all probability due to a deposition of chemical substances locally. Cases of acute rheumatism, acute arthritis deformans, etc., are due in a large majority of cases to infection by bacteria of the joint or joints through metastatic infection, the organisms being brought to the joint by the blood.

This idea, which has been growing during the past few years, is very helpful, chiefly for two reasons: (1) It teaches us how to prevent these polyarthritides, and (2) how to cure them. Having learned the situation of some of the primary points of infection, we can, by removing them early, often prevent the metastasis. In cases already developed we can often do more toward cure by removing the primary focus than we can accomplish by local or constitutional measures.

Some of the common portals of infection which should be considered are: (1) In the respiratory tract, the paranasal sinuses, including the maxillary antrum, the frontal sinuses, the ethnoidal and sphenoidal cells, the lungs (pneumonia is not infrequently followed by arthritic attacks, also influenza, chroic bronchitis and bronchieactasis). Tubercle bacilli and pneumococci are the bacteria most apt to get into the joints from the lungs. In the digestive system we find pyorrhea to be not an infrequent cause. There is no longer any doubt as to the tonsils being responsible for a large number of cases of metastatic streptococcus infection. Not infrequently in cases of acute arthritis resembling acute articular rheumatism streptococci are found. Either the palatine tonsils or the pharyngeal tonsil may be the primary focus. Chronic appendicitis may be, but has not yet been proven to be, a cause. Dysentery should also be considered. We have in the typhoid spine a good example of a metastatic infection occurring in ulceration of the intestine. In typhoid there are other definite evidences of metastases in the rose spots, and the acute splenic tumor. The genito-urinary tract is a common portal of entry both in the male (prostate, seminal vesicles and bladder) and female (vagina, Fallopian tubes, Bartholin's glands). While the gonococcus is the most common organism entering here, the tubercle bacillus, the colon bacillus and the syphilitic spirochache may also enter by this portal. The middle ear is to be looked upon occasionally as a primary focus, and extensive skin infections are often accompanied by arthritis. By keeping these points in mind we shall be much helped in planning our treatment of many of these cases and in preventing metastatic infection of the joints. These remarks concerning arthritis apply equally well to endocarditis.

Gonococcal Arthritis—Dr. Cole. Here is the best example of metastatic arthritis, and the idea of metastatic arthritis was first gotten from this. For a long time gonorrheal arthritis was considered as acute articular rheumatism, and many cases are treated today as such, especially in infants and children. Dr. Holt has drawn attention to this and has reported 30 cases in his Children's Hospital. The cases are often quite serious. Gonorrhea arthritis is common in adults. Some genito-urinary surgeons think that it occurs in from 2 to 5 per cent. of the cases of gonorrhea.

In 1905 there were ot this Hospital 29 cases of arthritis of undetermined nature, 44 cases of tubercular arthritis, 34 cases of acute arricular rheumatism, and 37 of gonorrheal infection. There are three groups: (1) Those cases seen by the genito-urinary surgeon with pain in the joints during the acute attack of gonorrhea. (2) Those presenting a picture like acute articular rheumatism; in a series of 50 cases 274 joints were involved, an average of six joints in each case; the joints are swollen, red and painful. (3) Cases seen in the surgical ward, in which careful attention is not paid to the history of other joints being involved.

The Course of the Disease—Most of the joints clear up in from three to four weeks, but in many cases one joint remains which gives trouble.

The pains in the joints after inoculation with the filtrate from gonococcus cultures is not the same as the true arthritis; it is a toxic arthritis. The essential point in the treatment is to get rid of the primary focus. There have been cases in the ward which have gotten well almost immediately when the urethritis and prostatitis have been carefully treated. Kocher advises opening and draining the seminal vesicles. It is supposed that in chronic cases multiple infections are taking place.

Vaccines—Fifteen cases have been treated here, but it is difficult to draw definite conclusions. Drs. Meakins and Cole feel, however, that the results have been good. Practically all cases have done well, and most acute cases have cleared up without stiffness. One patient had apparently recovered and gone to work again. He came into the Hospital later with pneumonia, and died in 10 days, and on opening his joints, inflammation was still found to be present, and the gonococcus was cultivated.

The diagnosis is often difficult. The pathological process may be any grade from simple hydrops up to phlegmonous arthritis. A lesion elsewhere in the body is, therefore, of aid. There may be pus in the joint and the gonoccus may be cultivated. Many cases are not clear, though, unless scrapings are made when the joint is opened. A case was shown illustrating the difficulty which is often encountered.

The Infectious Nature of Spondylitis—Dr. Baer. The question of etiology here is a difficult one. It is not simply a local disease, but the product of a general disease, just as in the other arthritides. The vertebral column is composed of a number of joints. As a working basis we have the following classification: (1) Infectious form, e. g., that due to the typhoid bacillus, the gonococcus, etc.; (2) rheumatoid arthritis, the arthritis of multiple joints, the atrophic form of Goldthwaite; (3) the hypertrophic form, which occurs late in life, and associated with Heberden's nodes. This classification of arthritis can be applied to spondylitis. (1) The typhoid spine, gonococcal spondylitis, staphylococcus spondylitis, etc.; (2) the form associated with multiple arthritis, in which ankylosis of the spine results with atrophy

and ossification of the intervertebral discs; you also get radiating pains; (3) osteo-arthritis, with proliferation of the cartilaginous edges and growing down over the ligaments.

Case 1. Typhoid Spine—The patient developed pain in the back in the course of typhoid fever. There are two types of typhoid spine: (1) Due to neuroses; (2) periostitis, with, at times, new bone formation. The patient's normal spinal curve persists; that is, there is present the normal lumbar lordosis and the thoracic kyphosis. But there is a limitation in motion, especially bending forward. He bends to the left better than to the right side. On stopping to pick up an object he keeps one hand on his knee and his back stiff.

Case 2. This is an example of the osteo-arthritic type. The patient was here in the hospital four years ago, and at that time he had been having trouble for three years. The history was of pains in the back, limp, loss of motion, sciatic pains, etc. The pain began in the neck, then the hips, and there was a great loss of weight. Finally he lost altogether the lumbar lordosis; therefore the dorsal kyphosis became more marked, and the spine is now ankylosed. The pains in the hips have persisted, but the shoulders are at present clear. The radiograph shows that there is an ossification of the lateral ligaments of the vertebral column, as well as of the anterior ligaments, and an obliteration of the intervertebral discs.

Case 3. Gonorrhœal arthritis—The patient is 26 years old and has had three attacks of gonorrhœa—10, 3 and 1 year and 3 months ago. With the second attack an inguinal bubo developed. Six months ago he began to have pain in both heels, and some time later pain in the back began. Exostoses were found on the oscalcis. Bony deposits were present between the third, fourth and fifth lumbar vertebrae, some of the freedom of motion having been lost and some of the lumbar lordosis. Cultures were negative, but gonoccoci were found in the tissues.

Case 4. This case is almost similar to the above.

Case 5. This is a most interesting case of staphyloccocus infection of the bodies of the vertebrae. The family history is negative but for the fact that his father was treated for tuberculosis. Some years ago he had some nasal and midear trouble. Last July (1906) the patient came here with the complaint of pain in the hips and down the back of the right leg behind to the knee. The pain was worse in the morning, getting better as the day advanced. There was some scoliosis to the right. Rest in bed afforded great relief, and he left the hospital in a short time feeling much better. In November, 1906, the pains began again. The spine was stiff and bent to the right and there was marked sciatica in the right leg. The patient was scarcely able to sleep at all at night. On admission to the hospital a second time in January, 1907, he was given a hard flat bed and an attempt was made to keep him supine. It was found impossible, however, for on lying flat he declared that he could not breathe well. On further examination his right ethmoidal and spenoidal sinuses were found full of pus. This condition was treated and the symptom in the back cleared up almost by magic. The back now is straight and there is practically no limitation to motion, while before flexion extension and lateral bending of the spine was very much limited, especially bending to the left side and flexion. He still complains of soreness in the throat and some disability in flexion of the neck.

(*Continued Next Month.*)

MARYLAND MEDICAL JOURNAL.

JOHN S. FULTON, M.D., *Editor.*

Associate Editors:

THOMAS R. BROWN, M.D. | HUGH H. YOUNG, M.D.
ROBERT REULING, M.D. | JOSE L. HIRSH, M.D.

BALTIMORE, JULY, 1907

HOUSING CONDITIONS IN BALTIMORE.

"BALTIMORE has no tenement-house problem." This pleasant assurance has been repeated so often and so confidently that Baltimoreans believe it. It is a pity to disturb a belief so agreeable, but there is a housing problem in Baltimore, and its points of distinction from the true tenement-house problem are perceptible only to technical minds of unusual sensitiveness. The Association for the Improvement of the Condition of the Poor and the Charity Organization Society have revealed the existence of very bad housing conditions in a report just published, based on a study of four districts by Miss Janet E. Kemp. This study considered 600 houses, including 1174 apartments, 3452 rooms, sheltering 4904 persons. Cellars and basements were found in use as dwellings in 58 out of 345 such places visited. In 697 apartments inspected, there was less than one person to a room in 69 apartments, and five or more to a room in 24 apartments. There were 912 water-supply fixtures for 1174 apartments, and 27 of these fixtures were for baths. Sometimes there were as many as two spiggots for one apartment, and 157 times there was but one spiggot for seven or more apartments. Water-closets were found in 9 houses, and 74 privy compartments were shared by more than 600 families. The proportion of the lot occupied by the building was determined in 248 instances. The house covered 40 per cent. or less of the land in 22 instances, 80 per cent. or more in 52 instances, and 2 dwellings covered all the land.

The six-story rookeries which dominate the common notion of a tenement-house may furnish more scare-head horrors, but three-story hives breed untimely death just as steadily. Souls and bodies ripen as ill and rot as early in shallow courts as in deep ones. Crowding begins when the population reaches one person per room. Two and a half persons per room is frightful overcrowding. In 348 apartments, in two of the districts investigated, the average was well above 2.5 persons per room, and in four apartments there were 8 persons per room. Comparing the results of this investigation with the conditions observed in other cities in the matter of one-room apartments, we find Baltimore credited with 15 per cent. of one-room apartments ont of 1174 investigated, while a similar study in Chicago gave 1.7 per cent. of one-room apartments, in Cleveland 5.5 per cent., and in Jersey City seven-tenths of 1 per cent. of one-room apartments. Fancy an eight-room house containing seven families of 36 persons! Fancy the comfort of 30 families having among them four privies! Picture the

amenities of life in Kaufman court, whose 13 families face each other constantly across the court, having no other outlook, and share among them seven privy compartments and one yard hydrant! The Street-Cleaning Department has no interest in this court, nor in any other court, nor in any of the many privately-owned alleys in Baltimore. These are all cleaned by their owners as often as the owners please, or as often as clean-up orders are enforced by the Health Department.

It is believed in New York and elsewhere that in Baltimore all buildings over two stories high and occupied by two or more families must be provided with fire-escapes. This singular illusion is based on the fact that the city ordinances do, in fact, make such provisions, and 8 out of 63 such houses investigated by Miss Kemp really have fire-escapes.

This timely report also exposes the lameness of the local definition of a tenement-house. The city charter defines a tenement as a house occupied or intended to be occupied by more than three families. This definition, of course, excludes three-family houses, which would be included under the prevailing standards in other American cities.

The committee recommends certain amendments of the Code section in "Tenements." These will undoubtedly excite opposition among owners of tenement property, and this opposition will be effective unless the report of the committee generates in the minds of thoughtful citizens a lively interest in the thousands who are submerged by these evil housing conditions. "My people," said a Ruthenian priest to Miss Kemp, "do not live in America; they live underneath America; America goes on over their heads."

BACILLUS CARRIERS.

Some time ago, in a Western city, while a group of physicians were dining, the talk turned upon recent studies of the routes of invasion by tubercle bacilli. An active popular campaign against tuberculosis was in progress, and a vigorous young campaigner, who had to speak an hour later, heard at table, for the first time, that the current of inspired air probably does not carry the tubercle bacillus all the way to the site of its mischievous activity. The young man was strongly impressed. His dinner was spoiled, and his speech—well, his speech forsook him. The foundations of his oratory seemed to have crumbled and carried him down. In this desperate situation he appealed to his right-hand neighbor for help. It was not very difficult to reassure him that his gospel of prevention was as sound as ever, and he as fit to proclaim it. He made a stirring address, though once or twice, when he came too near the unfamiliar ideas about inspiration, one could note his faltering.

The march of progress is not much of a walk. It has neither swing nor stride. The rear heel is kept firm till the front foot is down heel and toe. Then the weight is carefully transferred. In the pursuit of knowledge a man may be following his file leader with every appearance of confidence, but if he gets a push he expects a plunge, and becomes dizzy.

A vertigo of this sort, affecting a great many people just now, is due to important accessions of knowledge about the modes and agents of trans-

mission of infectious diseases. The general employment of cultural methods has acquainted us with "carrier" cases, i. e., individuals who carry about, and may communicate to others, the germs of a disease, though having themselves no signs or symptoms of the disease. "Carrier" cases of diphtheria have become almost familiar in the past ten years. Before we knew about the communicability of malaria, we knew about its latency. Long before we knew about the ubiquitous streptococcus, we were taught that almost anyone might communicate a deadly fever to a puerperal woman. Walking typhoid and pestis minor were known long ago, and we believed that all, or nearly all, communicable diseases might exist in a condition of latency, or in forms so mild as to cause no serious inconvenience to the subject and to defy diagnosis. Formerly, when we were more confident than we are now about the pathological relations of the pneumococcus, we knew that the pneumococcus is constantly present in the mouths of many healthy people. More modern experiences with cholera have shown that slight diarrheas are worth bacteriological investigation when cholera is present; and in countries where typhoid fever has been all but subdued, the chronic carrier of typhoid bacillus has emerged from obscurity to importance. While our knowledge of practical prevention has improved in this way, we have lost some of our fears of inanimate bacillus carriers. The fear of infectious persons seems to many people a greater fear than the fear of infectious things. Some, indeed, not having followed the growth of this knowledge, believe that progress is to stop at this point, and they prophesy gloomily about the strange obstacle, the human bacillus carrier. But the situation is altogether hopeful. It is past success in the control of disease which has brought this new knowledge within reach. The subsidence of epidemicity has uncovered the "carrier" case. When a disease is widespread the "carrier" case is submerged, out of sight, and relatively unimportant. This individual is as truly a product of epidemic conditions as are the bedridden and dying cases. Every chronic bacillus carrier is simply a more enduring record of a past outbreak, and the number of such infectious individuals must always be proportionate to the severity of past conditions. "Carrier" cases cannot be anything like so prolific of epidemic conditions as are the acutely ill. Possibly such cases can generate, but they certainly cannot maintain, epidemic conditions. Nor can the "carrier" case propagate his kind, at least not in numbers. That physiologic neutrality which will neither destroy a pathogenic bacterium, nor allow its specific energy to be unfolded, must always be rare.

As the other and more familiar agencies of transmission are brought more and more under control, the number of "carrier" cases must diminish. A time may come, however, when "carrier" cases, though less numerous, may be far more important. That will be when the other means of transmission have come under approximately perfect control.

In such a day the conditions of our times, with respect to the common infectious diseases, will be as far behind in human memory as the fortunate conditions of that coming day are far ahead in human vision. The "carrier" case has not loomed up as a sign of despair. On the contrary, we should be greatly encouraged by the glimpse of our residual problem. It is farther away than it appears, and, coming up directly ahead, it means that we are on the true course and all is well.

Medical Items.

BALTIMORE.

The proceeds of the concert given by the Vienna Male Choir on May 11 in Baltimore amounted to $1,526.36, which was distributed among the hospitals of the city.

Dr. Wm. H. Welch has resigned as a member of the Committee on Legislation of the A. M. A., and Dr. Rodman of Philadelphia has been appointed to succeed him.

Mr. Jacob Epstein has added $10,000 to his recent gift of $25,000 for the purpose of founding a Jewish hospital for consumptives. The maintenance of the hospital has been provided for by 24 citizens who agree to give $500 each annually.

Dr. Caleb W. G. Rohrer, for the past six years assistant bacteriologist of the State Board of Health, has been elected medical assistant to the State Board of Health. The position vacated by Dr. Rohrer's promotion has not yet been filled.

The most picturesque municipal work now going on in Baltimore is that of the Mosquito Brigade. The Health Department's mosquito jagers are being photographed at all the stages of the game, and all their maneuvers are chronicled.

MARYLAND.

The Board of Trustees of the Maryland State Sanatorium for Tuberculosis has appointed Dr. Bayard T. Crane of the Rutland, Mass., Sanatorium, as resident superintendent.

The State Department of Health has issued a bulletin on Fourth of July injuries, advising concerning the treatment, recommending the use of antitoxin, and announcing that antitoxin for free distribution is placed in the hands of all the local health officers.

GENERAL.

Pittsburg typhoid is again on the rampage. Of course.

Sunday calls in France are to cost double fees. The Congress of Practitioners has so decided.

An industrial settlement has been formed at Saranac to give employment to consumptives whose disease has been arrested, but who are not fit to endure again the conditions of city life.

The New Jersey State Sanatorium for Consumptives, at Glen Gardner, will be opened for patients in August. Dr. Henry H. Davis of Camden has been appointed medical superintendent.

The State of Georgia has decided that Dr. Crawford Long, who did pioneer work in anesthesia, shall be one of the two citizens who shall be commemorated by a statue in the capitol at Washington.

Havana is to have a tuberculosis sanatorium. It will begin with accommodations for 60 patients. The site is 12 miles from Havana, near Arroye Arenas. Havana has also a League Against Tuberculosis.

The Chicago Tuberculosis Institute has come into possession of a sanatorium, the Edward Sanatorium at Naperville, through the generosity of Mrs. Keith Spalding. Mrs. Spalding will also give $6000 a year for maintenance.

Mr. Henry Phipps of New York has sent $1250 to the Phipps Dispensary for Tuberculosis at Johns Hopkins Hospital. Of this sum $250 were for the purchase of books, and the remaining $1000 to be spent in as may be most useful to the dispensary.

The Chicago Department of Health will issue antitenanic serum to all its ambulance physicians on the Fourth of July, and will also furnish antitoxin on request to practising physicians who have to treat indigent persons for injuries received on that day.

Minnesota is to have a Pasteur institute, which will be opened August 1 at Minneapolis, under the direction of the State Board of Health. The Legislature, recently adjourned, appropriated $5000 a year for the maintenance of the institute.

The College of Physicians and Surgeons of New York (Columbia University) celebrated the one hundredth anniversary of its founding on June 12. Addresses were made by Dr. Wm.

H. Welch, Dr. S. W. Lambert, Dr. Thomas Darlington and Rev. Dr. Aked.

THE Medical Faculty of Paris has made regulations which will prevent the professors of anatomy, histology, physics, chemistry and pharmacology from serving as physicians, surgeons or accoucheurs in the hospitals, and will require them devote themselves exclusively to their teaching work.

QUARANTINE bars are to be raised in Texas against persons having advanced tuberculosis. This announcement is made by Dr. W. H. Brumby, the State health officer of Texas. Quarantine against cases of advanced tuberculosis might prove advantageous to the consumptives, if not to the State of Texas.

THE Imperial Board of Health of Germany furnishes seven different sera for diagnostic and medico-legal purposes. There is an agglutinating serum for typhoid, and one for cholera; a bactericidal serum for each of these diseases; an agglutinating paratyphoid serum, a dysentery serum and a precipitating serum for the blood test.

THE permanent home of the Henry Phipps Institute for the Study and Prevention of Tuberculosis is to be at the northeast corner of 7th and Lombard streets, Philadelphia, in the heart of a district where tuberculosis is most prevalent. The hospital will cost about $300,000. Mr. Phipps will also provide a sufficient endowment to make it self-supporting.

THE Indians of the Tulalip Reservation, Snobornish county, Washington, are said to be suffering an epidemic of influenza. Nearly 100 deaths are said to have occurred. There is an influenza, which has its endemic center in Southern Asia, and is vastly more fatal than the influenza which came to us from Siberia in 1889. The tropical sort of influenza may have attacked these unfortunate Indians.

IT is reported that the German habit of frequent family outings in the parks has been seriously disturbed of late on account of the dust raised by automobilists. Vigorous protests are made, the complainants saying that their outings no longer refresh them, but that, on the contrary, they are injured and annoyed by the dust. The Imperial Board of Health is considering the situation seriously in the hope of restoring to the poor and middle classes the fresh air which they enjoyed before the advent of the automobile.

A BOARD of medical officers will meet at the Bureau of the Public Health and Marine Hospital Service in Washington on July 15 to examine candidates for admission to the grade of assistant surgeon to the Public Health and Marine Hospital Service. Candidates must be between 22 and 30 years of age, and graduates of reputable medical colleges, and must furnish testimonials. The examination will be physical, oral, written and clinical. For invitation to appear before the board application should be made to the Surgeon-General, Public Health and Marine Hospital Service, Washington, D. C.

THE great work of preparation for New York's new water supply was formally begun on June 20, when Mayor McClellan started the excavation for the Catskill aqueduct. The water is to be stored in three reservoirs in the Catskills. Aqueducts will pass under the Hudson river at Storm King at a depth of about 700 feet, coming up at Brickneck, on the east side of the river. The course of the conduits from here on will involve less remarkable, but still very interesting engineering. The estimated capacity of the new system is 600,000,000 gallons daily, and the cost is estimated at $161,000,000. Eight or ten years will be required for the completion of this great work.

THE Society for the Suppression of Unnecessary Noises has secured the passage by the New York city council of a very useful ordinance. It provides that signs shall be placed on the corners of all streets in which a hospital is situated. The signs read "Hospital Street," and the areas bounded by these signs are to be known as "hospital zones." Within these hospital zones hucksters must not cry their wares, street musicians must not perform, street cars must run slow and avoid unnecessary whistling or gonging, teamsters must walk their horses, newsboys must ply their trade in comparative silence, and children must not collect in numbers nor make a noise. A fine of $10 is the penalty for disturbing these silent precincts with unnecessary noise. Health Commissioner Darlington and Police Commissioner Bingham are both said to be pleased with this ordinance, and will enforce it.

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THE WAR ON TUBERCULOSIS.

By John S. Fulton, M.D.,
Baltimore.

AN ADDRESS BEFORE THE MINNESOTA ASSOCIATION FOR THE PREVENTION AND RELIEF OF TUBERCULOSIS, FEBRUARY, 1907.

THE program which you have arranged, the public announcements made, the exhibition in progress and, more than all else, the people assembled here, would convince me that something important is afoot, even if I had dropped into this place from a distant planet, ignorant of your human nature and of the causes of your happiness and of your sorrow. To such an ignorant visitor you would perhaps explain this meeting by saying that Minnesota has 2,000,000 of people, subject to a disease which kills more than 2000, disabling other thousands of comparatively young persons every year, and that you have discovered means of checking this havoc. Then I should perhaps remark that such good news is of vital interest to every citizen of Minnesota, that hundreds of meetings like this must be in progress, and all other public business is likely to be neglected in Minnesota until your great campaign of life-saving is thoroughly organized. But I am no celestial stranger. This, I daresay, is the only public gathering of the sort to be found in Minnesota at this moment, and I feel sure that the people of this State are not enlisting by thousands in your crusade against tuberculosis. Outside these walls ten times your number of fellow-citizens are concerned with this problem more acutely than you, for the hand of the destroyer is upon their houses, and there is none to deliver them. Sad experience will not drive these thousands into your ranks, and for other tens of thousands I venture to say that they will not contribute to your cause very large amounts of time or of money or of service. And yet I have no doubt that many of you will live to see this monstrous epidemic begin its slow retreat, some of you will be glad that you enlisted and served a term or two, and a few of you will count it life's

supremest satisfaction that you gave from first to last the very best you had to this beneficent warfare.

I have not come to tell you how the spread of tuberculosis may be checked. That saving knowledge is not new, nor is it strange to this place, nor profound enough to justify your sitting still for half an hour to hear what I know about it. The essential truths, on which the prevention of tuberculosis may be undertaken confidently, are easily apprehended. Any intelligent person can grasp this knowledge well enough to talk in an interesting way about it. We could all become evangelists of this gospel so easily that the spread of information alone would suffice for the suppression of the disease if knowledge were in truth, as men say it is, power. But mere lodgment in the human mind does not convert knowledge into power. Stony ground, thorns, hard-beaten waysides and hungry fowl are found in almost every landscape and in every mind. Good seed, good ground and careful tillage are needed to bring the knowledge to fruitage. If to faith be added knowledge; and to knowledge, temperance; and to temperance, patience; and to patience, godliness; and to godliness, brotherly kindness; and to brotherly kindness, charity, then you have all the elements of power fitly compounded. So armed, you must translate this saving knowledge into wise laws, impose it upon your officials, engraft it on your politics, weave it into the fabric of your social conscience, teach it to your preachers, preach it to your teachers, and root it in the minds of your children "that their posterity may know it and the children which are yet unborn." All this must be done by a handful of people, and you are the people. This is the substance of my message—that you are the people who must do this thing. To you, and not to any others, this momentous underaking—the whole of it—is committed, and if I can help to bring you into full conscious possession of your power over the destinies of your fellow-creatures in this matter of tuberculosis, that is what I came to do. After that, no matter how large or how important the accessions to your numbers, you can furnish to every recruit a full portion of work without in the least diminishing your own activities. If I fail to help you in this way, then this is a speech running to waste. You will come to your own as fast as your hearts impel you, and no faster. As you decided the last preceding move, so you must decide on the next succeeding move by consulting your own hearts. Therefore if a word of mine opens up to any of you an attractive bypath away from the line of my remarks, forget me and follow the new trail. This movement is led by the spirit, and its success depends far more on your private thinking than on anyone's speaking.

In a recent address one of the wisest of modern physicians called attention to the long interval which always elapses between the conception of a great idea and its living birth—the period of latent or subconscious possession, as he calls it. Illustrations may be found in every field of human endeavor, but none more interesting than the incubation period of the belief that tuberculosis can be

suppressed. Every great movement, they say, is the lengthened shadow of a man, and many of us, if looking for the origin of the antituberculosis movement, would stop, I think, in the year 1882, in the laboratory where Robert Koch first made sure that a minute plant is the living cause of tuberculosis. But the story is much older. No one knows the date of its conception, but those who heard Koch's announcement, in 1882, knew that a child of great promise had quickened in the womb of time. Definite knowledge, practically useful in the struggle of man against tuberculosis, has been in the possession of the medical profession for more than a quarter of a century, and it might seem superfluous to ask whether the medical men of this day are in full, conscious possession and exercise of the power which the existence of this knowledge implies. But the question must be asked, for its answer will indicate the state of preparation of the profession to lead this campaign. Do medical men really know what they profess to know about tuberculosis, or are they merely incubating a few facts which may or may not be delivered at last to the world's use as organized, vital truth? Let me state briefly the grounds on which a medical man may doubt, and a layman may deny, that medical men are in full, conscious possession and exercise of this power.

With the knowledge that the seed of the disease is contained in the sputum of the tuberculous, and with means of destroying the sputum, medical men should have been fully prepared, if mere knowledge could have prepared them, to undertake the prevention of tuberculosis in any household where the disease was found. Means of destroying infectious material have been known and used by physicians from time immemorial, and a belief in the infectiousness of tuberculous sputum can be traced to antiquity. The identification of tubercle bacillus simply confirmed the views held by a respectable minority of the medical men of preceding generations. But the indisputable proof, which completed this knowledge, did not bring it into practical exercise. We do not find that medical men in attendance on cases of tuberculosis advised that the sputum be destroyed. The significance of the facts must have literally stared at them. Did they deliberately ignore it, or were their eyes hidden that they could not see? The universal prevalence of the disease must have made its restriction on a large scale seem almost hopeless. The little that one or two or a few physicians could do seemed hardly worth doing. But medical men, I am convinced, were not constrained to inaction by the magnitude of the undertaking. They did not try it on a small scale—not in the family, not even in one's own family. The physician's household was visited as often as any other by the lean specter; the physician himself was often attacked. But even in the narrow circle of his undivided mastery the physician's knowledge was not applied to its obvious use. Singularly sterile this knowledge must have been if neither conjugal love nor parental love nor the instinct of self-preservation could vitalize it. Is it conceivable that a man may know how to save his wife or his child or himself, and yet, in the face of

danger, remain unmoved by love or fear to exercise this knowledge? How shall we characterize such a man's infirmity? Let us be careful, for a later generation may inquire why we, professing to know how it might be done, failed to control tuberculosis in the State. That infirmity of our fathers which kept their knowledge barren may rob us of the fruits of far richer knowledge. We are just as infirm as our fathers, not toward this problem, perhaps, but toward some other problem which our children will solve, wondering why we, knowing enough, did not solve it in our day. Our fathers were infirm in faith. They did not add knowledge to faith. A new faith must grow beside the seed of knowledge, and faith is like a grain of mustard seed, the least of all seeds. The medical men of 1880 did not believe in what they knew about tuberculosis. They neglected the immediate and obvious utility of the facts for the sake of their remote and indefinite promise. That which is obvious to us was latent to them. They went on, as men have always done, in pursuit of new knowledge. The hope of a cure for tuberculosis possessed them, for this lure is older and stronger than that of prevention. But the claims of preventive medicine obtruded about as often as any new fact of importance was unearthed. The faithful continually reminded their brothers that tuberculosis ought to be prevented. Registration, disinfection and segregation, they said, were necessary. They did not know very well what they meant by registration or disinfection or segregation. The majority opposed the first two suggestions and agreed to the third. "Segregation," they said, "is necessary. Incipient cases should be treated in sanatoria. The way to prevent tuberculosis is to cure it." The majority supported these views by substantial reasons, for experience was available in proof that many cases of tuberculosis could be cured in sanatoria, and a certain control could thus be exercised over its spread. The sanatorium idea spread amazingly, making good much of its promise on both accounts of cure and prevention. Meanwhile the faith was growing in younger minds, and unbelief made room where old men died. The faithful ceased not to plead for registration, disinfection, special hospitals for advanced cases, legal restraint of the spitting nuisance, instructive nursing, and other measures indicated by enlarged knowledge and experience. But the profession has not, as a whole, moved the adoption of these steps. The sanatorium for cure remains to this day the one agency in the prevention of tuberculosis which is unreservedly approved and actively promoted by medical men. They believe in tuberculosis dispensaries and in hospitals for advanced cases; they favor laws against spitting; they speak temperate praise of instructive nursing; they are not opposed to disinfection; but they are quite unenthusiastic about all of these things. On the fundamental proposition of registration the medical profession has often been deeply and bitterly divided. Wherever registration is practiced the laws on the subject were passed through the influence of medical leaders, the great mass of the profession and of the public remaining

ignorant of or indifferent to the progress of events. This want of alertness is an evidence that the rank and file of the profession do not keep their knowledge of tuberculosis in the upper layers of their consciousness, and the surprise which ensues when the movement overtakes them shows that this knowledge, when brought to the surface, does not always arise to help, but sometimes to hinder. The conquest of inertia in New York city required 10 years of strong and patient administration.

It has not often happened that physicians have actively opposed legislation on this subject. I know of one instance in which the activity of physicans has prevented such legislation for several years past. In the community of which I speak, the majorities in the medical societies have used coercive tactics to restrain the minorities. Indignities are heaped on men who were formerly honored as leaders of medical thought. Because these leaders actively advocated the registration of tuberculosis and the free use of a public laboratory for the examination of sputum, the majority threatened professional and social ruin to their former leaders. The leaders are now silent, and the profession appears to present an unbroken front of open opposition to needed legislation. The thing of value, which the majority believe to be endangered by the proposed legislation, seems so vital to professional interests, or else so insecurely held, that the method of boycott has been employed for the purpose of suppressing the opinons of three or four prominent men. The organization of a liberal and enlightened profession has been and is perverted to this corrupt use. The barbarous device is successful, so far as professional opinion is concerned. But the movement which they hoped to check is still in progress, and likely to succeed. The leadership has changed. It is now a layman's movement. It is incredible that these misguided doctors intended to withdraw, en masse, from the world-wide crusade against tuberculosis. But that is what they have done. They have failed to perceive that this saving knowledge has been germinating for years in the minds of the lay public, and that the movement will not halt, even though every doctor in the land should sulk in his tent. This is an extreme illustration, and I do not mention it as characteristic of the profession to which I belong. There are stragglers even farther in the rear than these—the men, for instance, who are afraid to tell the truth to their tuberculous patients, and by feebly temporizing rob them of that precious interval which, at best, leaves to hope only the duration of a Minnesota twilight. Such men do not belong to these times or to our ranks. They are lost. It has been long since they got up at reveille, and they can lie down to sleep without taps. We need not concern ourselves much about them. These stragglers are likely to be forgotten by the Recording Angel, if she has not already inscribed their names on the list of overdues.

We started out to inquire whether the medical profession has at this time a firm and effective grasp on that knowledge which suffices for the prevention of tuberculosis. We have learned, I think,

that as late as 20 years ago this knowledge was all but useless in the hands even of the leaders, and that thousands of our contemporaries do not hold it in full conscious possession and exercise. We have seen that the last man is very far back, indeed. Measure the distance from this last man forward to those who are responsible for this gathering, and you will know the length of your procession. It would be most unfair to judge the status of this movement by the position of the last man in the procession. But it would be just as unfair, and for you it would be dangerous, to measure the influence of the medical profession as a whole by the power of its foremost men. It is for you, the leaders, to examine critically those qualifications for leadership which the lay public commonly attribute to medical men indiscriminately, and simply because they are medical men. If it should appear that the essential knowledge which we are considering is not an instrument in the hands of our brothers, but only a germinating idea in their minds, we must take careful account of this circumstance, for it enormously increases the responsibility of those who do feel themselves in full conscious possession of the truth about tuberculosis. This straggling procession, stretching no one knows how far behind you, is your command, but it is not your effective force. You cannot bring the whole of it to bear upon an objective point at short notice. Our allies in the laity are apt to think that every medical man is a prophet and evangelist of this gospel of bodily salvation, and that you are all of one accord in its spirit. But it is for you to know the condition of all your forces, and especially to strengthen and confirm the faith now growing among those of your own calling.

If the delinquencies of which I have spoken were exceedingly widespread or very refractory, I should not have called attention to them in the presence of a mixed assembly. I should have reserved that for a more familiar occasion. I do not condemn these weaknesses, and I hope you will not condemn them. Such infirmity belongs to all men. Hundreds of men, whom you cannot count on now, will be heard from by and by, when they have finished incubating their dormant knowledge—when their eyes see, and their ears hear, and they understand with their hearts, and are converted and made whole. Meanwhile the vitalizing, organizing power of this movement, so far as the medical profession is concerned, must remain in the hands of a few men.

It is worth your while to reflect a moment or two on the paucity of your members. Considering the great scope of your undertaking, and the time elapsed since its inception, the prospect may not seem very hopeful, if you are of a mettle sensitive to enumeration. But if that thought could have discouraged you, the movement could not have reached the hopeful status manifested in what I have heard before I came, and what I have seen since I came here. You are but a handful of men, but you belong to a great army of the choicest, most virile spirits which the race has yet produced. In every land where the light of science shines, and the faith of science burns, one may find other handfuls of medical men—your com-

panions in arms. To be counted among them is to be in the foremost files of time. If they were all assembled on one of your prairies, the confusion of speech would exceed that of Babel, but on one subject men would speak with cloven tongues, as of fire, and every man would hear in his own tongue wherein he was born. Everywhere, as you would learn, these little bands of men are doing the same thing, and doing it with power. They are propagating the truth about tuberculosis, not only among those of their calling, but to all men, meaning to pass the word back much beyond the hindmost medical man in the procession, even to the last man of all.

I have come here, primarily, to exhort you to think deeply about your weaknesses, and to come by that way into the temperate, charitable, and effective use of your strength. If I say that in one respect American physicians have done better than their comrades in other lands, I do not want to divert you for more than a moment from the contemplation of the particulars in which my countrymen may take lessons abroad. But we can improve, I hope, even in what is our best. American physicians have done more, I think, than any others to break through that traditional reserve which is said to be distinctive of medical ethics. If it is right to remove this ancient landmark, it is undoubtedly easier done in this country. Our fathers held it to be unprofessional to talk freely with lay people about the mysteries of their art; they would not speak in public, as a score of you are doing, to lay audiences on a medical topic. They shrank from newspaper publicity as the morning-glory from the sunshine. This modesty is, in my opinion, at least, very becoming, indeed, to some men; it is not incompatible with the truest manliness, and I trust we shall always have a few examples of it. But it is not a distinctively medical attribute, and most of us wear it simply because it has long been the conventional attitude of the physican toward the general public. A century ago medical men did not have much to communicate which the layman needed to know, but more than two centuries ago one of the wisest physicians who ever lived had something to say on this subject. In his "Religio Medici" Sir Thomas Browne said: "There are infirmities not only of Body, but of Soul, and Fortunes which do require the merciful hand of our abilities. I cannot contemn a man for ignorance, but behold him with as much pity as I do Lazarus. It is no greater charity to clothe his body than to apparel the nakedness of his Soul." "I make not therefore my head a grave, but a treasure of knowledge; I intend no Monopoly, but a community, in learning; I study not for my own sake, but for theirs that study not for themselves."

The rise of preventive medicine first awakened in the professional conscience a doubt about the propriety of the traditional reserve toward the general public, but it is this great problem of tuberculosis which has swept the physician into open publicity. It is the force of the movement rather than the spirit of the profession which has done this. I have seen physicians keep engagements to speak on this subject to small groups of plain citizens, with evident

fears that they might thereby give encouragement to cart-tail quacks. But they have all found their courage, and I know nothing more admirable than the willingness of many of my friends, able and busy physicians, to devote an evening to the spread of this gospel among the poor.

What gratifies me most in this public discussion of public questions by physicians is that my profession has thereby made its definite entry into politics. And it is a most appropriate entry, overlong in preparation, but freighted with the loving kindness that the ages have bred out of our ministry to sick and suffering fellow-creatures. We have launched a humane idea into politics. That is a good thing for the science of government, but a better thing for the science of medicine.

And now a word or two for those who have been drawn into this movement, not by any sense of technical responsibility, but because they have discovered in this movement the promise of extraordinary benefit to the race. I wonder if you lay workers have escaped the necessity of incubating this idea for years and years in your minds before it became an instrument of power in your hands. I do not believe that you escaped this period of incubation; at all events, I should expect you to prove it. It is far more probable that you incubated your faith under different forms, or else the knowledge was not overlaid or obscured by details as it was in us. I remember the visit of certain strangers from far countries to Jerusalem in the time of Herod. These men had long treasured a few bits of ancient Jewish learning—imperfect, fragmentary, and precious information. They supposed that any man in Jerusalem would know more than they did. When they arrived in Jerusalem they spoke to men in the streets, telling the little that they knew, and asking, "Where is the promised King to be born?" The men in the streets did not know, and finally the question came to the chief priests, to whom all this knowledge was quite familiar. And the chief priests, facile and perfunctory, said that the King should be born in Bethlehem. But the chief priests took no further interest in the strangers. And the strangers went to Bethlehem and found there the young child and his mother.

I find it difficult to believe that you have made better speed than we in developing power out of the facts which medical science has furnished you. Isn't it true that you have been less embarrassed in that the knowledge which has come to you is far less complicated than that which came to us? We will acknowledge, if we must, that your faith is more robust than ours, but I hope you are not going to insist upon your apparent advantage.

You heard me a moment ago congratulate my fellow-physicians on having launched a humane idea into the tide of politics. The humane impulse has not a long history in the affairs of government. It is older than the movement to restrain tuberculosis and older than the science of State medicine, but still quite young. As a physician, and not qualified to speak authoritatively on this subject, I should say that the humane idea became permanently

lodged in the practical conscience of the Anglo-Saxon at least shortly after the memorable winter's journey of John Howard. Howard's work set Farr and Chadwick to studying the causes of poverty. It was the beginning of the end of typhus fever, and that is the first chapter in State medicine. Another stem, springing from the same root, became that beneficent force which we now know as philanthropy. This is the stock from which the anti-tuberculosis movement derives its non-medical allies. These devoted men and women who have traced poverty and dependence to its roots, studying as well, and as successfully, how to prevent as how to cure; making sympathy scientific, but not less humane; giving to charity motives instead of emotions, and habits in place of impulses—these people undoubtedly had good preparation to receive the word that tuberculosis can be prevented. They had labored at the network of mischance which enmeshes so many of God's poor, and they knew that tuberculosis is one of the strong cords in that tangled web. It is not surprising that such enlightened people should have taken immediate notice of the announcement that tuberculosis could be prevented.

The treasures which were brought into this field by those who came from the fields of sociology were most acceptable offerings. There was a rich literature about housing, hours of work, wages, standards of living, recreation, family desertion, drink, social relations, school attendance, child labor and other subjects, fundamental to public hygiene, though little studied at first hand by professional hygienists. You got to the heart of this problem much ahead of us, enriched the common stock of knowledge with stores of information that we suffered to remain buried in the annals of the poor. You have been accurate and minute in your memoranda; you made logical numerical statements, in this respect excelling your friends of my calling. Moreover, you were never disturbed by questions of ways and means. You not only brought a virile faith to bear on your problems, but you had engendered in the minds of the charitable public a lively faith in the soundness of your judgment. All you have to do, apparently, is to say that such and such profits, in the alleviation of some form of distress, can be effected by such a sum of money. The money comes out of the air, for all I can see, and the profits follow the money. You have brought your skill to bear on public officials with remarkable effect; you have, in fact, the politicians in tutelage. The ablest lobbyists I know are sociologists. Indeed, I think they are ill-described as sociologists; they are simply humane politicians.

I mention last the best of all the contributions from lay sources to the anti-tuberculosis campaign. Change of environment, as you know, produces interesting variations in plant life, and pathologists are in the habit of producing certain alterations in the pathogenic bacteria by growing them in special media. It is possible to increase or diminish the virulence of certain organisms in this way. The virus of the rabies of dogs, for instance, becomes more virulent if propagated through rabbits, and the first step toward the cure of rabies depends on this circumstance.

It seems to me that the facts about tuberculosis were but moderately communicable while they grew in the minds of physicians, but after a few years' growth in the minds of lay people, and especially of sociologists, the truth about tuberculosis became highly infectious. This, I think, is your best contribution to the campaign; that you have made this knowledge virulent, so that it will substitute a life-saving for a death-dealing epidemic.

You will note that I seem to have been kinder to the lay warriors than to the medical combatants. If I knew the laymen as well, it would not have been so. Very likely they have missed the road as often as we. From now on we shall know each other better, and when you have fully indoctrinated us, and have been indoctrinated by us, we may freely exchange the pleasantries of brotherhood. You shall teach us politics, and we will teach you medicine. We shall borrow faith from each other. The lender of this commodity is never impoverished.

We shall need a large capital of faith—enough to save us from repeating past errors, and from the fear of future ones. The time to be afraid of new mistakes is after they have been made. Mistakes will occur anyhow, and it is better to go fast enough to overtake new blunders than slow enough to keep company with old ones. We are always a little behind the meridian time, and in this conquest of tuberculosis our start must be made at the mark originally set for our fathers (though they missed it) in the narrow circle, in the home of the tuberculous. This does not mean that we should withhold credit for the very good progress made by our fathers, starting from the wrong mark. We can do our own work without humbling either ourselves or our fathers. We shall be judged by our children, whose standards will be better than ours, and as we respect our fathers, so we may look ahead to the respect of our children. The ignorance and apathy of our own generation are the objects of our attack. Our children will deal with other kinds of ignorance, but with the same old apathy. The weapons that avail against ignorance and apathy are knowledge and zeal, and zeal is merely a short name for the kind of knowledge which has grown up into faith, the kind of faith which medical men have acquired from intimate association with their lay fellows in this task of restricting tuberculosis. If we have the faith and can keep it, this generation will run its lap in good time. That is all we should expect or desire. For this is a team contest, and not individual competition. It is a kind of relay race. This generation has left the mark. It has no concern but to cover the course in the shortest possible time. I need not worry about the time of the last lap or about the man who is to run the next lap for my side. My successor is a competent athlete, I trust, and he will get on the mark when I swing round into the stretch. He may shout at me to hit it up, but that will not necessarily mean that I am slow or he fast. His interest in me is ephemeral. He has only to touch and go. The particulars, by laps and performers, are left to the clerks of the course. The team wins.

Current Literature.

REVIEW IN NEUROLOGY.

Under the Supervision of Robert Reuling, M.D., Baltimore.

A Study of the Neurofibrils in Dementia Paralytica, Dementia Senilis, Chronic Alcoholism, Cerebral Lues and Microcephalic Idiocy. Solomon C. Fuller. (From the Pathological Laboratory of the Westborough Insane Hospital.) *American Journal of Insanity*, Vol. LXIII, No. 4.

The author's article consists of 10 pages, exclusive of references and 12 remarkably well-executed plates of drawings and microphotographs. The reader is therefore urgently advised to consult the original communication, as a review can hardly do justice to the subject treated.

"*Introduction.*—A great part of the present interest in the neurofibrils of the ganglion cell may be traced to the notable researches of Apathy, who in 1897 made his most important contribution to this subject. Many workers have since then added to our knowledge of these elements of the nervous system, but while we have gained a clearer conception of the anatomical arrangement of the fibrils, of their physiological function there is much undetermined."

The work of Max Schultze was the first to attract any great attention or won anything like serious consideration from histologists. The remarkable drawings which appeared in Stücker's Handbuch d. Lehre von d. Geweben, and since then often reproduced. To the fibrils coursing through the ganglion cell Schultze gave the name of primitive fibrils, and held they were the essential conducting elements of the nervous system.

Kupffer in 1883 was the first to demonstrate in stained specimens the neurofibrillary structure of the axis cylinder in specimens fixed in osmic acid and colored with acid fuchsin.

As the method employed by Apathy proved inapplicable to vertebrate material, in 1898 Bethe published a description of the molybdate method which he had devised and by means of which the neurofibrils in the ganglion cells of vertebrates were for the first time sucessfully demonstrated.

The neurofibril arrangement which Bethe described differed somewhat from that given by Apathy, for in the Bethe preparations a netlike arrangement of the fibrils within the cell was not so prominent—indeed, failing in many cells. This led Bethe to the conclusion that "die Fibrillen bei den meisten Zellarten glatt durch

den Zellkörper hindurch laufen, ohne im Innern mit einander in Verbindungen einzugehen, wie dies bei Wirbellosen in so auffallender Weise geschieht." Bethe cautions that in determining whether or not a given picture is a true union only those instances where the fibrils present a forked or Y-shaped appearance should be considered as such, and that X-formations should be excluded.

Paton in 1900 described the appearance of the ganglion cells in the cerebral cortex of pigs which had been treated by a method of his own for the demonstration of neurofibrils. In Paton's paper the fibrils are represented as coursing "straight through the cell processes without being connected to each other," but in the cell body there are connections between individual fibers, so that a very wide-meshed network is formed.

Held, after studying Cajal's method of fibrillary staining, adds, by the way of reservation: "Höchstens lassen sie eine Meinung zu, das es vielleicht zwei Arten von zentralen Ganglionzellen gebe—solche, in denen nur verkreuzte Fibrillen vorhanden sind, und solche, in denen es zur Ausbildung von zusammenhängenden Fibrillennetzen kommt."

The author from his studies on the neurofibrils of the ganglion cells of birds, rats, calves, pigs and man, in which the methods of Cajal, Bethe and Bielchowsky were used, chiefly the last, lead to somewhat different conclusions. In pathological material, at least, certain cell pictures present themselves with sufficient frequency as to warrant consideration. In the illustrations accompanying the author's article it will be seen that while a decided net structure is shown, there is on examination a marked difference in the nets. Where the meshes of the net are intact they present a fair degre of regularity in shape and size. Beneath the outer net there is another which stains palely and diffusely, and the trabeculae of this inner net are irregular in shape and size, and its meshes are occasionally crossed by the trabeculae of the outer.

We look upon this outer net as a disintegrating Golgi net. Golgi nets are occasionally encountered in Bielchowsky preparations, but in his cases of dementia paralytica they were found almost always in a state of disintegration. The inner net suggests very strongly the netlike coagulative material of Jäderholm, although it is by no means entirely impossible that the picture it presents may not be the equivalent of a disintegrating indocellular net. In support of the view that this is, perhaps, a net of coagulative material the following is offered: Distinct fibrils are nowhere to be made out, not even in the dendritic stump, which contains generally indocellular fibrils; at least the independent fibrils appear more vulnerable than those of the processes.

"Whether we can consider the neurofibrils as the chief conducting elements of nervous impulse as advanced by Apathy and

Bethe, or just what part, if any, the interfibrillary substance takes in conduction, a contention of Max Wolff is still undecided. The theory of Bielschowsky as to physio-chemical basis of conduction is certainly comprehensive and appears worthy of consideration. The experiments of Bethe on this subject are most interesting."

As regards the neurone concept, there are those—Cajal, Forel, Barker and others—who see in all of this neurofibril work nothing which invalidates the neurone theory, but rather an anatomical confirmation of the doctrine. On the other hand, Nisl, Held, Bethe and others appear equally convinced of the untenableness of the anatomical unity of the neurone.

* * *

Death During a Katatonic Seizure in Dementia Precox. J. George Dreyfus. *Centralblatt für Nervenheilkunde u. Psychiatrie,* Vol. XXX, No. 239.

As a rule, the seizures occurring in dementia precox are more or less attacks of fainting and epileptiform convulsions, which end, as a rule, in recovery. One meets at times, however, with serious states of coma of somewhat longer duration. That such comatose states may lead to paralysis, followed by death, has, in the author's opinion, not been previously described."

In the *Neurol. psych. Wochenschrift* (Bd. 7, page 225) Tetzener describes a case of katatonia which developed severe convulsions and ended in death. Tetzener excludes epilepsy and paralysis as etiological factors in his case.

Dreyfus, however, is not entirely satisfied that paralysis or an undiscovered epilepsy may not have been present in Tetzener's patient, as such conditions can only be excluded by careful microscopical studies of the changes in brain and spinal cord, as katonia may, according to Kraeflin, accompany both conditions. A macroscopical examination, as one well knows, cannot exclude the presence of a progressive paralysis. In the case to be now cited death occurred during the first seizure, and the difficulty of correct diagnosis was even greater.

W. H., aged 31; physician. His grandfather showed evidence of psychic disturbances during middle age. He imagined everything was dirty, and constantly cleaned objects within his reach. His mental state gradually cleared up, only to return after his sixtieth year. No other hereditary stigmata.

The patient has always enjoyed fair health. Has had none of the diseases usual to childhood; was a good scholar, an industrious student, moderate in all respects, and passed satisfactory examination. Soon showed a tendency to avoid the company of his colleagues, and was generally unpopular.

The first evidence of mental disturbance showed itself during

May, 1903. He was in a state of constant apprehension and excited; believed that legal complications would follow some harmless remarks he had made. He gave up his practice for a short time on the advice of friends. In August hallucinations affecting the sense of smell developed. He was fully convinced that he emanated disagreeable odors and was being shunned by people; Americans were devising instruments to harm him; letters he mailed were being removed from the boxes. He formerly spent much time working in electrical apparatus. In September he conceived the idea that some powerful instrument for technical electrical experiments was exerting a powerful influence on his body. This instrument he believed to be in Hamburg. He even telegraphed for protection to the State authorities. Then followed a period of improvement, and he took up the practice of ophthalmology, doing several squint and cataract operations. In October, 1904, the hallucinations again appeared and were even more marked than previously. His interest in his practice lessened rapidly. Ideas of great self-importance now became manifest. He wrote to the papers, even inserting a notice of his formal engagement to a lady of rank. His condition soon necessitated his removal to a private hospital, where the diagnosis of dementia precox was made. After four months he was removed to the clinic in Basel. He remained there from May, 1905, until his death in October, 1906.

The examination failed to reveal the presence of any organic disease. The pupils reacted promptly to light. The reflexes were all normal. The mental state throughout suggested that found in dementia precox—slow progressive loss of the mental faculties, with a state described as negativismus; occasional refusal of food, so that feeding with a tube was resorted to; hallucinations were present; stereotype manner of speech, etc. In the early part of 1906 he had every appearance of an advanced state of katonia. He constantly assumed the same positions, most frequently standing with bent back and lowered head, with his hands thrust deep in his pocket, occupying a seat in a corner of his room, failing to react to the ordinary external stimuli. In September the mental hebetude had progressed so far that he would only utter the following: "Fine weather today," and this no matter what the conditions of the weather, no matter how severe the rain or storm. With this loss of mental power his bodily weight increased steadily.

On October 20, after his supper, without any premonitary symptoms, his right side became paralyzed. The head fell towards the right shoulder. The entire right side seemed paralyzed. At the same time clonic spasmodic twitching appeared in the muscles about the corners of the mouth, also in the extremities; the face became cyanotic; froth appeared at the mouth, the muscle spasms lasting several minutes, the face becoming pale; respirating ceased and the pulse could not be felt. Death followed. The autopsy failed to show any pathological changes in the organs of the chest or abdomen to account for his death. On opening the skull noth-

ing abnormal was found, the dura and pia being normal, and not adherent. The brain weighed 1592 gr. Sections of the brain and cord were now prepared for histological study and stained after the methods of v. Giesson, Nissl (methylene blue and thionin) and that of Pappenheim; methy-green-pyronin for elective staining of the plasma cells. In all the sections studied the arrangement of ganglion cells appeared normal. The cells themselves showed no well-marked changes. The blood vessels are moderately congested. Their walls are not thickened. The perivascular lymph spaces are not dilated; certainly no cellular elements, and, what is more remarkable, certainly no plasma cell infiltrations. The pia is entirely normal. The sections from the spinal cord also failed to show any histological changes.

The author therefore comes to the conclusion that this case represents an example of a functional psychosis ending in death. He refers to the articles of Kraepelin, Weber and Reichards on the lethal outcome in functional psychosis.

* * *

Difficulties in the Diagnosis of Brain Abscess. Barton H. Potts. *The American Journal of the Medical Sciences*, Vol. CXXXIV, No. 424.

The author refers to Spiller's remarks on the diagnosis of brain abscess: "The diagnosis of brain abscess depends chiefly upon the signs of some more or less rapidly-developing lesion of the brain, with the discovery of a purulent process in the body or a wound of the head. Abscess of the brain, without any evidence of pus elsewhere, may be extremely difficult to diagnose."

The cardinal symptoms of cerebral abscess are neuroretinitis or choked disk, subnormal temperature, headache, chill, vomiting, slow pulse, slow cerebration, stupor, high leucocytosis, with high polymorphonuclear percentage, and cerebrospinal fluid free from pus. Dana gives a good description of cerebellar seizure, viz., sudden, unexpected attacks of extreme vertigo, roaring in the head, relaxation of the limbs and falling to the ground in a semiconscious state. Sachs calls attention to the at times early involvement of the facial nerve, not paralysis, but reactions of degeneration. He claims that the early development of reactions of degeneration in the facial nerve indicates the probability of an abscess in one of the lateral lobes of the cerebellum ratherthan a sphenoidal abscess. Unfortunately, the cases usually do not present groups of symptoms sharply defined. The fundus changes are usually late. The temperature is frequently subnormal, but sometimes does not fall below 101° F. The slow pulse is a reliable guide when present, but in some cases it never goes below 80°, keeping in perfect accord with the temperature. Kernig's sign may be present, but is more generally absent; it is almost constant in meningitis.

Abscess of the frontal lobe is usually attended with no localizing symptoms, unless it is situated about the base of the third frontal or ascending frontal convolution. If the abscess is large, the pupil of the same side is usually dilated; if small, the pupil may be sluggish or contracted. If a tempero-sphenoidal abscess be small, there are usually no localizing symptoms; when large the adjacent centers and nerves are likely to be affected either by pressure or inflammatory action.

Facial palsy may be due to inflammation in the tympanum or in the cortex. In the former case the paralysis is complete; in the latter the patient is usually able to move the eyelid. If due to antral lesion, it is on the same side; if due to involvement of the cortex, on the opposite side to the lesion.

Aphasia was noted in three of the author's cases, and points to abscess in the left tempero-sphenoidal lobe; its absence has no significance. If it be sensory aphasia, word deafness, the lesion is probably in the posterior part of the lobe; motor aphasia, in the anterior portion. Paralysis of the third nerve is sometimes seen in large abscess of the tempero-sphenoidal lobe, and when complete the picture is characteristic—ptosis, external strabismus and fixed and dilated pupil. The eyeball can be moved only downward and outward.

The author reports the following cases:

Case 1.—A case in which brain abscess was suspected. At the time of operation the bone over the dura was found to be destroyed for an area about 2x3 cm., but the dura was covered by healthy granulations. The membrane was found to be considerably congested, but there was no opening, no marked pressure, and there was good pulsation. Following operation the patient showed a typical meningitis. The temperature ranged from 102° to 103° F.; the pulse 100 to 110, and was steady. Kernig's sign was present. Lumbar puncture gave apparent relief and showed some pus with streptococci. There was no change in either eye, but the patient was irritable and rather excitable. He died seven days after operation, and the autopsy showed a small abscess in the left tempero-sphenoidal lobe.

Case 2.—A laborer had had a history of suppuration of the middle ear dating back 20 years. For about a week before admission to the hospital he had complained of intense headache.

On the day of admission he suddenly became unconscious just after eating breakfast. He threshed his arms like flails and had to be strapped. He talked in a rambling manner. Once after admission his pulse was 62. There were no changes in the eyes; he vomited once. In the absence of all other indications the brain was explored. There was very great pressure and full pulsation, but after careful search no abscess was located. He died 10 hours after the operation, and a small abscess below the first temporal convolution on the left side was found at the post-mortem.

The author reports another case of interest, and the reader is referred to the original article.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

NOTICE.

AS NOTED in previous numbers of the JOURNAL, the semi-annual meeting takes place on September 11th., 12th. and 13th. during our trip to the Jamestown Exposition. The boat will leave at 8 P. M. on Wednesday the 11th. and is due in Norfolk the next morning, giving a good view of the Hampton Roads and the naval ships from the water.

The scientific sessions will be held on the boat, while going and returning. (Members wishing to present papers will please notify the Chairman, Dr. G. M. Linthicum, at once.) It is planned to hold one meeting in connection with the Maryland Day Exercises, on the 12th. at which addresses will be made by the Governor and others.

The return trip will be made on Friday night, September 13th.

PAID SUBSCRIPTIONS TO THE OSLER TESTIMONIAL FUND.

Janeway, Dr. Edward G., 36 West 40th. St., N. Y.	$100.00
Jarrett, Dr. Harry S., Towson, Md.	5.00
Johnson, Dr. Robert W., 101 W. Franklin St., Balt.	50.00
Kelly, Dr. Howard A., 1418 Eutaw Place, Balt.	1000.00
King, Dr. John T., 1425 Eutaw Place, Balt.	10.00
Knapp, Dr. H. C., 1214 E. Preston St., Balt.	5.00
Lankford, Dr. Harry M., Princess Anne, Somerset Co., Md.	10.00

Lord, Dr. J. Williams, 1011 N. Charles St., Balt.	100.00
Mallock, Dr. A. Hamilton, Ontario, Canada	100.00
Miller, Mrs. Mary M. K.	10.00
Miller, Dr. William E., 2239 Pennsylvania Ave., Balt.	5.00
Mills, Dr. James J., 853 Park Ave., Balt.	10.00
Mumford, Dr. James G., Haddon Hall, Boston, Mass.	25.00
Musser, Dr. J. H., 2047 Chestnut St., Phil.	100.00
Nichols, Dr. Jos. L., Saranac Lake, N. Y.	100.00
O'Donovan, Dr. Charles, 10 E. Read St., Balt.	100.00

MEETINGS OF COUNTY MEDICAL SOCIETIES.

ALLEGANY COUNTY MEDICAL SOCIETY.

A MEETING of the Allegany County Medical Society was held July 16 in Cumberland, and was well attended.

Dr. A. R. Walker read a paper on "Cancer."

The committee appointed to secure a permanent home for the society reported that they had secured a room in the County Court House, and the formal papers are in course of preparation.

The society will hold its September meeting in its new home and its August meeting in Midland.

CAROLINE COUNTY MEDICAL SOCIETY.

A MEETING of the Caroline County Medical Society was held Thursday, June 27, at Denton. There were present eight of the ten active members of the society and Drs. Charles O'Donovan, President of the Faculty, and F. J. Kirby from Baltimore.

The meeting was extremely satisfactory and all present felt that the society was now re-established on a firm basis.

The regulation Constitution and By-Laws were adopted and one new member, Dr. J. L. Noble, was elected.

HOWARD COUNTY MEDICAL SOCIETY.

THE regular quarterly meeting of the Howard County Medical Society was held at the Howard House, Ellicott City, Md., July 2, 1907. The meeting was called to order at 2.30 P. M. by Dr. Wm. B. Gambrill, President.

The minutes of the last meeting were read and adopted.

Dr. J. W. Lacy proposed the name of Dr. Albert Nice for membership, which was referred to the Board of Censors.

Insurance fees were discussed and carried over to next meeting.

Dr. Wm. R. Eareckson submitted a fee table, which was adopted after much discussion.

The following members were present: Drs. W. B. Gambrill, J. W. Lacy, S. A. Nichols, W. R. Eareckson, S. J. Fort, B. J. Byrne, W. C. Stone, A. Williams, L. G. Owings.

Luncheon was served at the hotel. The meeting adjourned.

REPORTS OF COMMITTEES, ETC., SUBMITTED TO THE HOUSE OF DELEGATES, AT THE ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY, TUESDAY, APRIL 23, 1907.

TREASURER'S REPORT.

THE following report shows the receipts and expenditures from January 1 to December 31, 1906.

The amount, $1966.00, was received from the City Society between January 1 and December 31, 1906, but an additional $840.00 was advanced by the City Society to assist the Medical and Chirurgical Faculty in paying off obligations that were due before the expiration of the year 1905. These two amounts show the total actually paid into the treasury for the year 1906 to be $2806.00. There was no necessity during the last months of 1906 for drawing on the advance dues of 1907, so that all collections for 1907 will show in the annual report of the year. While there is a small deficit, the actual financial condition is better than it has been for several years.

In addition to the appended statement, there are in the hands of the treasurer one one thousand dollar United Railway 4 per cent. bond donated by Dr. Wm. Osler to the Endowment Fund, and one one thousand dollar United Railway 4 per cent. belonging to the Baker Fund, and $428.28 in the savings department of the Commonwealth Bank.

TREASURER'S FINANCIAL STATEMENT.

January 1 to December 31, 1906.

Medical and Chirurgical Faculty of Maryland.

RECEIPTS.

Balance from last report	$265.95
Rent of Hall, non-affiliated societies	112.00
" " Hall B.C.M.S. for section meetings	200.00
Dues of members, Baltimore City Medical Society	1966.00
Dues of members, County Medical Societies	963.00
" " non-resident members	41.00
Baker Fund, interest	40.00
Exhibits, annual meeting	30.00
Contribution to Library Committee Fund, 4 Med. School	100.00
Contribution to Frick Library Fund	450.00
Medical Journal Company	403.00
Baltimore City Medical Society, Clerical Assist.	15.00
Total	$4586.45

EXPENSES.

Salaries		$1205.00
Telephones		135.85
Coal and wood		209.25
Gas		156.90
Repairs etc. to property		468.64
House expenses		137.43
Water rents 1905 and 1906		33.23
Fire extinguishers		45.00
Revision Medical Practice Act		110.85
Attorney's fee		50.00
Medical Journal Company		606.35
Return of membership fees		6.00
Programme Committee		106.08
Postage		49.00
Frick Library account		450.00
Baker Fund account		54.14
Library account,	Subscription to Journals	334.71
" "	Binding	181.85
" "	Association of Med. Lib.	45.00
" "	Customs entry	7.55
" "	Library Congress cards etc.	14.84
Supplies and printing		114.44
Incidentals		81.67
	Total	$4604.38
	Deficit	17.93

WILLIAM S. GARDNER,
Treasurer.

Audited by
T. A. ASHBY, M.D.
S. T. EARLE, JR., M.D.

SECRETARY'S REPORT 1906-7.

THE amount of work accomplished in the secretary's office is much larger than most members have any idea, and it might not be out of place to make a brief statement of what has been done. The secretary has kept in touch with all the county societies by means of continuous correspondence, and in some cases the work of the county officers has been aided by the central office. The material, for Baltimore, for the new directory of the American Medical Association was furnished by the secretary's office, and proofs of the directory for the entire state were corrected and brought up to date. A card catalogue of all the members with their financial statement has been kept as usual. The scrap-book of the lay press reports about the medical profession has been continued this year, and has proved of great interest to the readers in the library.

The work of organization has been pushed steadily and many members have taken active part. Societies have been visited by the

president, Dr. Woods, also by Drs. Earle, W. S. Gardner, H. Harlan, J. S. Fulton, L. M. Allen, J. M. H. Rowland and others. There is an organized society in every county in the state, and almost all of these are in a most active healthy condition. Several are still in need of a little more thorough organization, and I trust that this will come within a short time.

The secretary particularly invites correspondence on any topic that may be interesting or perplexing to the component societies, or their members, and would urge that any member having a grievance would report the same promptly to the secretary's office so that it may be corrected.

The secretary desires to convey his thanks to the librarian, Miss Noyes, and also to Miss Fort, who has acted as assistant to both librarian and secretary.

Following is a detailed account of the membership:

STATEMENT OF COMPONENT SOCIETIES
APRIL 30, 1907.

Membership.....	Paid.....	SOCIETY.	Reinstatement and transfer.....	New members.....	Deceased, resigned or removed.....	Dropped.....
33	32	Allegany County Med. Soc.....	2	3	1	1
21	18	Anne Arundel County Med. Soc..				1
514	449	Baltimore City Med. Soc.....	6	53	9	14
57	41	Baltimore County Med. Soc.....	10	2		6
9	9	*Calvert County Med. Soc.....				
11	10	Caroline County Med. Soc.....	1	2		
33	21	Carroll County Med. Soc.....		3		
23	23	*Cecil County Med. Soc.....		1		
14	11	Charles County Med. Soc.....	1	3		
17	13	Dorchester County Med. Soc....	1	4		2
49	47	Frederick County Med. Soc.....	1	4	2	3
9	2	Garrett County Med. Soc.....		2		
9	8	Harford County Med. Soc.....		1		
16	14	Howard County Med. Soc.....			1	1
8	6	Kent County Med. Soc.....		2	1	1
26	27	*Montgomery County Med. Soc..		5	1	
19	16	Prince George's County Med. Soc.	1	1	1	1
14	11	Queen Anne's County Med Soc..	1	2	2	
6	3	St. Mary's County Med. Soc.....				
18	18	Somerset County Med Soc.....		3		
14	11	Talbot County Med. Soc.....		3	1	1
39	30	Washington County Med. Soc...		5		
8	6	Wicomico County Med. Soc.....	1		1	2
12	12	Worcester County Med. Soc.....				
979	838		25	99	20	33

**Indicates that all members were paid in advance to State and County Society.*

A FEW NOTES FOR THE UNIFORMITY OF ADMINISTRATION IN COMPONENT SOCIETIES ARE GIVEN BELOW.

(a) Dues paid before February 1st. are paid in advance for one year's membership together with the MARYLAND MEDICAL JOURNAL. Physician's defence against alleged malpractice is granted only to such members as have paid in advance.

(b) A member is in good standing if dues are paid before April 1st. If not paid by that time the MARYLAND MEDICAL JOURNAL is discontinued, with privileges of the Faculty.

(c) If dues are not paid ten days before the annual meeting of the Medical and Chirurgical Faculty, the member is suspended without further action on part of the component society, and reported by the State Secretary to the National Society as ineligible to attend the annual meeting of the American Medical Association as a member.

(d) Members may be reinstated any time during the year upon payment of their dues.

(e) Members more than one year in arrears are dropped from the roll.

(f) County Society members admitted between January 1st. and March 31st., pay $2.00 dues to the State Society; members admitted between April 1st. and June 30th., pay $1.50; members admitted between July 1st. and September 30th., pay $1.00; members admitted after October 1st., pay $2.00 which is credited as paying in advance for the next year.

(g) Baltimore City Society members are voted upon on first Tuesday of December and April. Applications presented between April and December should be accompanied by a membership fee of $7.00, which will be credited for the year in advance, and those presented between December and April should be accompanied by a fee of $5.00, which will be credited for the balance of the same year. Applicants receive all privileges of membership prior to the consideration of their names and if they be rejected the fee will be returned by the Treasurer.

JOHN RUHRAH.

REPORT OF THE BOARD OF TRUSTEES.

THE Board of Trustees at its first meeting during the past year elected,

Dr. Charles M. Ellis, Chairman.

Dr. G. Lane Taneyhill, Secretary.

Dr. John W. Chambers, Treasurer.

The vacancy caused by the lamented death of Dr. I. Edmonson Atkinson, a member of the Board, was filled by the election of Dr. Taneyhill.

The Chairman is ex-officio the representative of the Board in the House of Delegates. Dr. E. N. Brush was appointed alternate.

The Treasurer, under the direction of the Board, made personal inspection of the securities, policies of insurance to the property of the Faculty in the possession of the Secretary, a bonded officer. He reported to the Board an itemized account thereof.

At the meeting of the Board held in March the President of the Faculty submitted a statement of the action of the Councillors on authorizing the appointment of a Committee, of which Dr. E. N. Brush is Chairman, and conferring upon it certain powers, to wit:

To solicit and collect monies for the purpose of providing a new Hall for the Faculty.

To employ architects to prepare plans for the same.

To select and acquire in the name of the Trustees a suitable site for the building.

The present condition of the Hall, so inadequate for its purposes and so dangerous to the safety of its invaluable library, is a perpetual source of anxiety and solicitude to the Trustees. We have therefore given our cheerful acquiescence and approval of this movement, and sincerely hope that such action will be taken by the Faculty at this annual meeting as will give certainty of its early success.

The present value of the lot and building is estimated at $15,000 with insurance of $12,000. The value of the library, although great additions have been made to it in the past year, is still conservatively placed at $45,000 and the portraits at $5000 with insurance of $18,000, making a total of $30,000.

CHARLES M. ELLIS,
Chairman.

REPORT OF THE COUNCIL.

YOUR Council have met with all possible regularity. A quorum composed generally of City members transacted the routine business of the Faculty. Some of our County members came when they could and their presence was always gratifying.

The principal work done outside of routine business this year has been (1) The adoption of the Maryland Medical Journal as the medium of publication of Faculty matters.

(2) The revision of the fee table.

(3) The announcement of operations scheduled for the day at each Hospital on the blackboard of the Faculty library. This should prove of interest and instruction to City and County members desirous of knowing what is doing.

Respectfully submitted,
ROBERT W. JOHNSON, *Chairman.*

REPORT OF THE LIBRARY COMMITTEE.

Mr. President and Gentlemen:—

The report of the Librarian gives so excellent a resumé of the workings of the Library, that little can be added to it.

Your Committee desires to direct especial attention to the recent

reports of the Frick Library and the Book and Journal Club, which show that the Library has received the sums of $6630 and $5180, respectively, from these sources during the past ten years, a yearly average of nearly $1200.

As the appropriation from the Faculty is barely sufficient to defray the office expenses and the cost of binding, it is apparent that the usefulness of the Library is dependent upon these two funds, $40 a year derived from the Baker fund, and the smaller gifts of individuals.

Accordingly, we would suggest that members of the Faculty take occasion, when opportunity offers, to express their appreciation to the contributors to the Frick fund and impress upon them how valuable their help has been. Moreover, the members should feel a personal responsibility for the continued activity of the Book and Journal Club. Only eighty seven subscriptions were paid during the past year, when at least double so many members could subscribe without making any sacrifice. It should be remembered that the Faculty dues are very low, and combined with the additional yearly subscription of $5.00 to this fund, would still amount to much less than the dues usually charged by similar organizations.

Your Committee would call attention to the arrangement which has been made with the principal medical publishers, by which all the new medical books are sent to the Library on approbation, and are placed in a special book-case for a certain period. This affords the members a ready means of inspecting recent American publications and materially aids the committee in the choice of books.

We would also respectively suggest that great care be exercised in the selection of members of the Library Committee. The judicious expenditure of the funds at its disposal requires careful consideration, and is best accomplished by those who are actively interested in medical literature. Accordingly, places upon it should not be regarded as complimentary, but should be reserved for those who appreciate the value of books, and are willing to interest themselves in the advancement of the Library.

In view of the present earnest attempt to raise money for the erection of a new building, it is unnecessary for us to insist upon its urgent need. It is, however, with great satisfaction that we have learned that the Council has authorized the construction of an office in the court-yard adjoining the Frick Library. This will do away with the necessity of using the reading-room for office purposes, and, by restoring it to its original function, will add greatly to the usefulness of the Library and the comfort of the members.

Respectfully submitted,

J. WHITRIDGE WILLIAMS,
Chairman Library Committee.

LIBRARIAN'S REPORT.

April 15 to December 31, 1906.

Mr. Chairman and Members of the Library Committee:—

That the Library report may coincide with the adoption by the Faculty of the calendar year, only statistics for the last eight months of 1906 are quoted. In consequence the list of donations will be disproportionately small, as the greater number of gifts are made in the first quarter of the year.

Two things of interest to the borrower have been adopted during the year: The sending of postcards to remind the physician that the book borrowed is due at the expiration of the time limit; and a printed announcement "that a fine of 25 cents will be charged, for each day overtime, on unbound books or journals which, as a special concession, are loaned members for only 24 hours", is given with each publication so loaned. While this has materially decreased the amount collected from fines, it has been found most satisfactory. There were 703 books borrowed since last report and 2290 readers have consulted publications in the reading room.

There has been no change in the 162 current journals on file. Of these, 14 are donated through the Association of Medical Librarians, 53 by the Book and Journal Club, 27 by exchange, 1 by Dr. J. C. Hemmeter, 57 by subscription of Library Committee, 1 by Dr. G. J. Preston, 1 by Dr. J. Ruhräh, 2 by the University of Maryland, 4 by Dr. J. W. Williams, 1 by College of Physicians and Surgeons, 1 by Dr. A. P. Herring.

Another appeal has been made to members of the Faculty to deposit all material published by them, whether in book or reprint form, in the Library that it may contain a complete history of their work. Many such books are noted in the list of donations, but the matter has been overlooked by some of our writers. The largest gift since the last report was that of Dr. J. A. Chatard, who has presented several hundred books of considerable value, but, as it has been impossible to accession these to date, they will be listed with the 1907 donations.

The Library now contains 16,103 volumes, 5212 of which are bound journals. These figures show that the increase in the past ten years equals that of the entire 76 years of its previous history. The removal to our present Library Building in 1895 is largely responsible for this; but Dr. Osler's interest, and the foundation of the Book and Journal Club and the Charles Frick Library Fund, reports of which are appended for the past decade, have been important factors.

The Library Building is now crowded to its limit, and, as there is no possible means of enlarging its present capacity, the need for a new fireproof building is imperative.

The gifts for the year are as follows:

Books—Baker Fund, 16; Dr. L. F. Barker, 1; Boston City Hospital, 1; Dr. J. W. Bovée, 1; Dr. S. C. Chew, 1; Dr. J. C. Chisolm,

154; Dr. C. P. Emerson, 2; Frick Fund, 206 (Dr. W. Osler 13, Dr. H. B. Jacobs, 13); Dr. H. Friedenwald, 1; Drs. J. Friedenwald and J. Ruhräh, 1; Dr. J. C. Hemmeter, 1; Dr. A. D. Hirschfelder, 2; Hynson, Westcott & Co., 1; Dr. H. B. Jacobs, 27; Library Committee Fund, 3; Dr. T. B. Marden, 1; Medical Journal Company, 7; Dr. G. W. Overall, 1; Dr. H. O. Reik, 1; Research Society, College of Physicians and Surgeons, 1; Dr. W. S. Thayer, 1; Dr. S. Theobald, 1; Dr. E. McE. VanNess, 1; Dr. J. W. Williams, 3; Transactions and Reports of Societies, 49; by binding journals, 98.

Reprints and Monographs—Dr. L. F. Barker, 3; Dr. E. N. Brush, 1; Mr. A. Carnegie, 1; Mr. C. P. Fisher, 2; Dr. H. Friedenwald, 12; Dr. A. P. Herring, 1; Dr. Reid Hunt, 1; Dr. R. H. Johnston, 3; Dr. H. A. Kelly, 15; Dr. E. S. McKee, 1; Miss M. G. O'Bryan, 1; Dr. H. E. Peterman, 2; Dr. J. Ruhräh, 2; State Board of Health, N. J., 3; Dr. W. R. Steiner, 1; Dr. S. R. Taber, 3; Treadwell Library, Massachusetts General Hospital, 1; Dr. F. B. Turck, 2; University of Heidelberg, 35; Universitäts-Bibliothek Jurjevski, Dorpat, 10; Dr. A. Vander Veer, 3; Dr. J. W. Williams, 1; Dr. R. Winslow, 2.

Miscellaneous Journals, etc.—Dr. H. H. Biedler, Dr. F. E. Brown, Dr. F. M. Chisolm, Dr. W. S. Green, Dr. W. L. Howard, Dr. H. T. Marshall, Parke Davis & Co., Dr. W. B. Platt, Dr. W. S. Thayer.

PETTY CASH FUND.

Receipts.

Balance brought forward April 15, 1906	$34.53
Fines on books overdue	16.42
Sale of duplicates, etc	10.60
Total receipts	$61.55

Expenses.

Assistance	$21.50	
Cleaning basement	7.50	
Drayage	5.15	
Express	6.35	
Incidentals	3.90	
Total		$44.40
Balance		$17.15

Respectfully submitted,

MARCIA C. NOYES,
Librarian.

Library Committee,

J. WHITRIDGE WILLIAMS.
H. BARTON JACOBS.
MARY SHERWOOD.
HARVEY W. CUSHING.
WM. RUSH DUNTON, JR.

REPORT OF THE FRICK LIBRARY.

1896-1906.

The Charles Frick collection of the Medical and Chirurgical Faculty Library was founded ten years ago by Messrs. William F. and Frank Frick in memory of their brother, Dr. Charles Frick.

Mr. Wm. F. Frick furnished the Reading Room of the Faculty Library, known as the Charles Frick Room, and both he and his brother have contributed a definite amount each year for the purchase of books on general medicine. Since the death of Mr. William F. Frick his contribution has been continued by his children.

It would be difficult to estimate the value of this collection of books to the profession, representing as it does the most recent medical publications in English, French and German. Particular care has been taken to purchase the latest and best books upon urinary diseases, a subject in which Dr. Charles Frick was greatly interested; and special attention has been given to collecting biographies of celebrated physicians and books of a general nature written by or about them. Every department of medicine is represented by carefully selected works, and files of important journals, transactions and reports have been purchased.

The Library is rich in the classics of medical literature, many of the old masters being found in the original. The earliest of these is the 1497 edition of Celsus. Others are: Paulus Aegineta, 1532; Albinus, 1737; Albucasis, 1541; Aretaeus, 1735; Astruc, 1740; Bartholinus, 1655; Bell, *Sir* C: 1802-14; Bright, 1827-1831; Brodie, 1834; Eustachius, 1707; Fallopius, 1575; Fracastorius, 1739; Hippocrates, 1546, and 1657-62; Hunter, J., 1835-37; Hunter, W., 1762; Jenner, 1800; Malpighi, 1673; Mead, 1704; Morgagni, 1724; Oribasius, 1554; Paracelsus, 1894; Portal, 1770; Swammerdam, 1669; Theophilus, 1703; Willis, 1664.

A most unique collection of Theses by American students at the University of Edinburgh, 1760-1810, was presented to this library by Dr. Wm. Osler. This rare collection came from the Library of the late Prof. Hope of Edinburgh and is the only one in any library in this country. Numerous other gifts have been made by friends of the library, particularly by Dr. Osler, and Mr. Reverdy Johnson, who have contributed largely in money and books.

During the year 1906, the files of two valuable French journals were added. These with the new books purchased, and the gifts of Drs. Osler, Jacobs and others give a total number of 231 editions, making the entire collection number 3010 volumes. Some of the most valuable acquisitions in the ten years are shown in the accompanying list.

The usefulness of the collection is demonstrated by the number of physicians who consult books in the Frick Reading Room each year. The total number of readers for the ten years is 40,176. In this room have been hung a portrait of Dr. Charles Frick and a bronze memorial tablet, the gifts of Mr. Wm. F. Frick, also crayon pictures of two pioneers of the profession in Maryland, Dr. C. F.

Wiesenthal and Dr. John Crawford, these latter the gift of Dr. Osler.

J. WHITRIDGE WILLIAMS,
Chairman, Library Committee.
MARCIA C. NOYES,
Librarian.

FINANCIAL STATEMENT OF FRICK FUND.
1896-1906.

Subscriptions.

Mr. Wm. F. Frick	$4750.00
Mr. Frank Frick	505.00
Dr. Wm. Osler	575.00
Mrs. H. B. Jacobs	400.00
Mr. Reverdy Johnson	300.00
Mr. J. Swan Frick	100.00
Total	$6630.00
Expenditures	6275.00
Balance	$354.94

Subscriptions for 1906.

Mrs. H. B. Jacobs	$200.00
Mr. J. Swan Frick	100.00
Dr. Wm. Osler	100.00
Mr. Frank Frick	50.00

January, 1907.

(Signed,) HENRY BARTON JACOBS,
Treasurer Frick Fund.

A Short List of Some of the More Important Works in the Charles Frick Collection.

Allbutt, T. C., *ed.*, System of medicine	9	vols.	1896-1900
Archives genérals de médecine	130	"	1823-1889
Besnier, E., *et al.*, La pratique dermatologique.	4	"	1900-1904
Brouardel, P., *et al.*, Traité de médicine et de thérapeutique	10	"	1895-1902
Brouardel, P., *et al.*, Traité de médicine, 2d ed.	10	"	1899-1905
Bouchard, C., *ed.*, Traité de pathologie générale (6 pts.)	5	"	1895-1901
Buck, A. H., *ed.*, Reference handbook of medical sciences	8	"	1900-1904
Celsus, A. C., De medicina; octo libri			1497
Centralblatt f. allg. Pathologie	7	"	1890-1896
Centralblatt f. Bacteriologie	18	"	1887-1895
Centralblatt f. klin. Medicin	15	"	1881-1894
Centralblatt f. Gynäkologie	19	"	1877-1895
Charcot, J. M,, Leçons du Mardi à la Salpetrière, 1887-89	2	"	1892-1889

Charcot, J. M., Oeuvres complètes	9	"	1892-1890
Charcot, J. M. et Bouchard, C. *ed.,* Traité de médicine	6	"	1890-1894
Coll. of Physicians in London. Medical trans.	3	"	1768-1785
Debove, G. M., et Achard, C., Manuel de médicine	6	"	1894-1895
Deutsches Archiv. f. klin. Medicin	52	"	1866-1894
Ebstein & Schwalba, Handbuch der praktischen Medicin	5	"	1899-1901
Edinburgh Hospital Reports	6	"	1893-1900
Edinburgh Med. Jour	23	"	1855-1878
Eichhorst, H., Handbuch der speciellen Pathologie und Therapie	4	"	1895-1897
Eulenburg, A., *ed.,* Real-encyclopädie der gesammten Heilkunde	30	"	1894-1906
Fortschritte de Medicin	13	"	1883-1895
Fournier, A., Oeuvres complétes	15	"	1882-1906
Gerhardt, C. & Seifert, O., Lehrbuch der Kinderkrankheiten	2	"	1897-1899
Grancher, J., et Comby, J., Traité des maladies de l'enfance	5	"	1897-1898
Grancher, J., et Comby, J., Traité des maladies de l'enfance, 2d ed	5	"	1904-1905
Gurlt, E., Geschichte der Chirurgie	3	"	1897-1898
Guy's Hospital Reports (London)	35	"	1839-1896
Holmes, O. W., Collected works	14	"	1898-1899
Hutchinson, J., *ed.,* Archives of surgery	10	"	1890-1899
Locke, John, Works of	9	"	1824
Local Gov. Board Reports, Lond	50	"	1861-1903
Masters of Medicine	8	"	1897-1900
Medico-Chirurgical Transactions (London), v. 23-62	40	"	1840-1879
Neurologisches Centralblatt	13	"	1882-1895
Nothnagel, H., Spec. Pathologie u. Therapie (36 pts.)	24	"	1894-1907
Penzoldt, F. & Stintzing, R., *eds.,* Handbuch der speciellen Therapie	6	"	1899-1895
Quain, R., Elements of anatomy (9 pts.)	3	"	1892-1896
Revue de Medicin	20	"	1878-1900
St. George's Hospital Reports (London)	10	"	1866-1880
St. Thomas' Hospital Reports (London)	26	"	1870-1897
St. Bartholomew's Hospital Reports (London)	33	"	1865-1897
Strümpell, A., Lehrbuch der speciellen Pathologie u. Therapie	3	"	1896
Strümpell, A., Lehrbuch der speciellen Pathologie u. Therapie, 2d ed	3	"	1899
Theses by American students at University of Edinburgh	121	"	1760-1810
Trans. Academy Med., Ireland	16	"	1883-1898
Transactions Clinical Society (London)	13	"	1868-1880

Trans. Medico-Chirurgical Society (Edinburgh)	16	"	1882-1897
Thompson-Yates Laboratories Reports (v. 7, pt. 1)	6	"	1900-05, 06
Trans. Pathological Society (London) 3 indexes	49	"	1846-1898
Twentieth Century Practice of Medicine	21	"	1895-1903
Verhandlungen d. Congresses f. Innere Medicine	16	"	1882-1898
Virchow's Arch. f. path. Anat.	142	"	1847-1895

STATEMENT FROM THE BOOK AND JOURNAL CLUB.

1896-1906.

SINCE its organization in 1896 The Book and Journal Club has collected $5180.00 by voluntary contributions. The amount by years is as follows: 1896—$515.00; 1897—$615.00; 1898—$470.00; 1899—$380.00; 1900—$460.00; 1901—$465.00; 1902—$455.00; 1903—$535.00; 1904—$410.00; 1905—$440.00; 1906—$435.00. In addition to paying for binding many journals, this money has purchased annually 56 journals and 270 books. In order to subscribe to these journals it is necessary to obtain $300.00 yearly, and for its entire expenses the Club needs at least $500.00 every year.

HENRY BARTON JACOBS,
Chairman.

DR. W. ROYAL STOKES,
Secretary-Treasurer.

REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION.

To the President and Members of the House of Delegates:

During the past year no matters concerning legislation have been referred to the Committee on Public Policy and Legislation, and, there having been no session of the General Assembly of the State, no subject has come before the Committee requiring its action.

It is evident that the activities of the Committee on Public Policy and Legislation will necessarily be chiefly during the period of meeting of the State Legislature and in preparation for such meeting.

WILLIAM H. WELCH, *Chairman.*
JOHN D. BLAKE.
JOHN W. CHAMBERS.

REPORT OF COMMITTEE FOR FUND FOR RELIEF OF WIDOWS AND ORPHANS OF DECEASED MEMBERS.

To the House of Delegates,
Medical and Chirurgical Faculty of Maryland:

We have the honor to report the condition of the "Fund for the Relief of Widows and Orphans of Deceased Members," at this date, as follows:

One $500 first mortgage, 5% University of Maryland bond, market value	$500.00
Amount in Commonwealth Savings Bank	463.35
	$963.35

There have been no calls upon the Fund during the year.

In conclusion we ask for the adoption of the following resolution:

Resolved—That the sum of $100 be appropriated to the "Fund for the Relief of Widows and Orphans of Deceased Members."

Respectfully submitted:

EUGENE F. CORDELL, M.D.
J. I. FRANCE, M.D.
S. A. NICHOLS, M.D.
D. W. CATHELL, M.D.
J. F. SOMERS, MD..
Committee.

Society Reports.

THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY.

MEETING HELD MARCH 4, 1907—DR. BARKER IN THE CHAIR.

(*Continued from last month.*)

Roentgen Rays in Arthritis—Dr. Frederick H. Baetjer. Since the *x*-ray shows practically no changes in the joints in the acute arthritic cases, I will speak tonight only of the chronic infections.

In this radiograph, No. 1, of an infectious case of arthritis the cartilaginous surfaces have been entirely destroyed, consequently allowing the bones to come much nearer together. In the more advanced cases there will be actual destruction of bone and atrophy, due to absorption of lime salts. In tuberculosis the cartilaginous surfaces are also destroyed, but the picture is different in that there is a general hazing and blending of the bones entirely different from that of an infectious arthritis. Radiograph No. 2 shows a healed gonorrheal joint. As in other cases, the articular cartilages are gone, but the bone outline remains perfectly distinct.

This radiograph, No. 3, is of a hypertrophic arthritis. As you can readily

see, the head of the tibia is thickened, and in a number of places there are small exostoses.

Radiograph No. 4 shows a joint after a severe gonorrheal attack. This plate is interesting in that there has been such an increase in bone formation that at first glance it looks like a hypertrophic arthritis.

Radiograph No. 5 is shown as a type of atrophic arthritis. In this condition we have destruction of the cartilage, evidenced by the bones being close together, absence of new bone formation and atrophy of the bone due to absorption of the lime salts.

Radiograph No. 6 is of a syphilitic joint. In these cases we find no change whatever in the joint surfaces. At the junction, however, of the cartilage and the periosteum there is a formation of new bone and a periostitis. This condition is always typical of syphilitic joints.

Radiograph No. 7 is an example of the changes that occur in the hip joint after typhoid fever. The cartilage has been entirely destroyed, with some erosion of the bone, and the head has united with the acetbulum, making a stiff joint.

These radiographs that I have shown tonight are from typical cases where the changes have been marked. Sometimes it is very difficult to make a diagnosis in the borderline cases. Occasionally we may have a joint which will show extreme atrophy of the bone, indicating an atrophic type of disease, but at the same time there will be exostoses simulating the hypertrophic form. It seems to me that the changes in the joint depend upon two things—the individual resistance and the severity of the infection. Therefore we may have the same etiological factor in two cases and yet widely different pathological conditions.

MEETING HELD APRIL 15, 1907—DR. NORTON IN THE CHAIR.

The Operative Treatment of Subdeltoid Bursitis—Dr. Baer. It has only been in the past few years that the true condition in subdeltoid bursitis has been recognized. It was formerly thought to be a form of ankylosis in the joint. Codman was the first to show how the inflamed bursa could prohibit motion. Anatomy: There are usually two parts—subacromial and subdeltoid—which are separate. The walls are thin and there is a serous lining. A small portion lying beneath the coracoid process is spanned by the coraco-acromial ligament. It is this which prevents the swollen bursa from passing upwards, and thus limits movements of the arm. On cadavers the bursa has been injected with wax and then motions attempted. The arm could be abducted 10 degrees, and then further abduction was prevented. Etiology: The causes are varied. The lining is serous, and therefore subject to all changes found in serous coats. Trauma is the chief factor, however. Pathology: This varies according to etiology. (1) Walls normal, but the bursa is filled with fluid. (2) Walls thickened, some fluid and a few adhesions. (3) Walls thickened and the bursa entirely obliterated. (4) Tuberculous, the bursa being filled with cheesy matter. There may be acute, subacute or purulent bursitis. Pain: This may be present during the first few days; later it is only felt on moving the arm. It is, as a rule, worse at night. Swelling: This is rarely present in chronic cases. When present it is over the anterior aspect of the humerus and under the coracoid process. Atrophy: The supra and infraspinatus and

also deltoid muscles may show some atrophy. Restriction of motion: This is the chief symptom. Anterior and posterior motions are fair; anterior rotation is bad. Abduction is usually limited to 10 or 15 degrees. As the bursa passes under the ligament there is often a click heard. The radiograph is negative except as a differential point in ruling out fractures. When very dense scar tissue has formed a shadow may be shown, however. The operative treatment is complete excision of the bursae. This first case is shown merely to present the clinical symptoms.

Case 1. Patient fell four weeks ago and hurt his shoulder. He came to the hospital 10 days ago, and has had some treatment with the paquelin cautery. There is slight atrophy of the supra and infraspinatus muscle, and also slight swelling over the deltoid region. There is pain on motion. The arm can be abducted 15 degrees, and then the scapular moves. He can put his arm behind his back, but in marked chronic cases this cannot be done.

Case 2. This man is a lithographer, and his work necessitates constant use of his right arm. About 18 months ago he began to have pain in his right shoulder, which increased until he had to stop working. There was no atrophy except of the biceps. There was some swelling over the coracoid process. As the arm hung at the side there was no pain. Abduction of 15 degrees was allowed. At the operation the bursa was exposed and fibrous adhesions found. Cultures proved negative. The bursa was excised. In order to make sure that the joint was normal, the capsule was incised and the joint examined and was found to be normal. The wound was closed and the arm was put up for a week in a position of 120 degrees abduction. Fourteen days after the operation all movements of the arm were good, including abduction of 120 degrees. The patient returned to work, and has continued for 21 months with no inconvenience.

Case 2. A plasterer. The family history was negative but for the fact that an aunt had tuberculosis. The personal history is negative. Six months ago he noticed pain in his shoulder and had to stop work. The pain was very intense on movement; was worse at night and in damp weather. The arm could be abducted only 10 degrees; then there was a click, and no further abduction was allowed. There was no atrophy. He was operated upon in January, 1907, and a bursa, swollen and thickened, a mass of scar tissue, was found. It was removed entirely and full abduction was obtained. The arm was placed in a Velpeau bandage. It is now two and a half months after the operation, and motion is absolutely normal. Cultures were negative.

Case 3. The patient came to the Hospital on February 5, 1907. Two months before he had fallen from a scaffold and struck on his right shoulder. There was slight swelling over the deltoid and abduction of only 10 degrees. At operation the bursa wall was greatly thickened and the bursa obliterated. This was excised and the arm put up with a Velpeau bandage. It is now seven weeks since the operation, and all movements are good except abduction, and this is not quite 90 degrees. In this case the greater tuberosity of the humerus was comminuted.

In acute cases of subdeltoid bursitis counter-irritation is indicated. If rheumatic in origin, try salycilates and aspirin. For chronic cases which have resisted all other treatment, operation seems to offer the only relief.

Putnam, in 1902, advocated repeated anesthesia and passive motion to break up the adhesions. Codman's method was to break up the adhesions and put the arm up in extreme abduction (120 degrees)) and outward rotation for some days. By these procedures damage was often done, such as dislocation or injury leading to thrombosis. Moreover, the adhesions often returned and the bursa became thickened again.

The treatment here advocated is complete excision, the bursa being approached by separating the fibers of the deltoid muscle. The advantages are that all the motions can be tried during the operation, there is no danger of tearing the adhesions, no chance for their return, and the arm can be put up in a comfortable position.

Some Interesting Complications of Suppurative Otitis Media—Dr. H. O. Reik. During the past few months it has been my good fortune to see a number of interesting cases of mastoiditis complicating acute suppurative otitis media, and from this group I have selected four cases to report this evening because they illustrate very well some points of interest of this disease. The special point I would emphasize is the mechanical element in the determination in the direction of its progress. I have been endeavoring to impress upon the students in attendance upon the otologic clinics the fact that purulent otitis media is a dangerless disease only so long as it is strictly confined to the tympanic cavity, when it concerns us principally from the point of estimating the possible impairment of function of the sound-conducting apparatus of the organ of hearing, but that, surrounded as the tympanum is by structures more important to life, the problem, when an inflammation breaks through the tympanic bounds, becomes a far more serious one. It is by extensions from the middle ear that such complications as mastoiditis, lateral sinus thrombosis, extradural abscess, meningitis and cerebral and cerebellar abscess are produced generally, or that a general systemic infection results, and once a pyogenic disease has invaded the cellular structure of the temporal bone and assumed an aggressive attitude there is no safe prediction as to where it will end.

It is a debatable question as to whether acute suppurative otitis media is strictly confined to the space described anatomically as the tympanum. In what proportion of cases the secretion actually enters the antrum has long been a matter for speculation, and no less an authority than Politzer believed that such an invasion is invariable. This compels us to look upon every case of purulent otitis media as a grave affection. Whether or not the antrum is always coincidently involved in tympanic infection, it must be admitted that the opportunity for inflammatory trespass from one cavity to the other is always present, and, clinically, we have come to look upon this large cell of the mastoid process as part of the middle ear. The normal histologic structure of the mastoid part of the temporal bone is subject to wide variations, the antrum mastoideum and the apical cells near the tip of the process being the only fairly constant cellular spaces existing therein. The localization of other pneumatic areas, however, may play an important part in determining the course which a destructive suppuration will pursue. The speed with which an inflammation advances here depends upon the virulence of the invading organism and the density as well as the resisting power of the bony structure. By a process of molecular disintegration or ulceration the abscess cavity grows as the necrosis advances. Naturally,

the more dense the bone the slower will the pernicious changes proceed; the more cellular its components and the larger the vacuoles, the more rapid and extensive will be the destruction.

Thus in a purely pneumatic type of mastoid the entire internal framework may be rapidly broken down and the cortex perforated. In the diploetic or partially eburnated form the necrosis, advancing in the direction of least resistance, may descend toward the apex of the mastoid, ascend toward the cerebral cavity or proceed anteriorly, posteriorly, internally or externally toward the digastric fossa, the lateral sinus, the labyrinth or the other surface, respectively, according to the resistance encountered.

When perforation occurs on the external surface of the mastoid process we have produced a common type of the disease, the subperiosteal mastoid abscess, so easily recognized by symptoms of boggy swelling behind the ear and a flaring out of the auricle until it assumes a position at nearly right angles to the side of the head. It should not be necessary to say that no physician should ever permit a case of mastoiditis to reach that stage if the patient has been steadily under his observation. To wait for such a condition before advocating a surgical intervention is to give the disease an opportunity to extend in some other direction through the less resistant tissues than the hard, bony cortex into dangerous territory. The cases I have chosen to describe to you this evening illustrate very clearly four of the possible routes by which a suppurative otitis with mastoiditis may extend beyond the temporal bone.

Case 1. When the necrotic tract takes its course through the internal surface or the anterior border of the tip of the mastoid process the abscess breaks into the digastric fossa and establishes the so-called "Bezold" abscess. The natural tendency of pus collections in this neighborhood is to wander down the neck along the sheath of the sterno-cleido-mastoid muscle. This is well shown in the history of Mr. C. H., 35 years of age, who came to the dispensary of the Johns Hopkins Hospital January 21, 1907. His illness began with a severe earache on the 24th of December, 1906, and the discomfort from this source had continued in a variable degree. For three nights prior to the dispensary visit he had been unable to sleep on account of the pain in and behind the right ear, and for 24 hours he had noticed a decided soreness in the right side of the neck. At no time had there been any discharge from the ear. His temperature was 100 degrees F., pulse 96, and there was marked tenderness over the tip of the mastoid. The tympanitic membrane had not ruptured, but was intensely congested. Paracentesis was performed at once, and the pus was found to contain a pure culture of pneumococci.

The patient was unwilling to submit to the operation of mastoidectomy until January 25, at which time the tender spot in the neck had become a painful swelling of considerable size. The mastoid was very sensitive, being unable to stand a pressure of more than 100 grams. There was a leucocytosis of 12,000, with a hæmoglobin percentage of 95. At the operation the surface cortex was found to be very hard and thick. The antrum contained pus and there was a necrotic perforation through the inner surface of the tip cell, permitting a regurgitation of pus from the digastric fossa. By partially detaching the anterior border of the tendon of the sterno-cleido-mastoid muscle and introducing a pair of artery forceps about two cm. it

was possible to evacuate the cervicle abscess, so that it was not considered necessary to make a counter-puncture below for drainage. Pus from the mastoid and from the cervical abscess showed pneumococci, as had that from the middle ear. The patient has fully recovered, the whole region closing in slowly by granulation.

Case 2. This case illustrates what happens when a mastoid tip is perforated through its posterior border and the purulent materials invade the posterior triangles of the neck. In this particular case, however, the septic invasion was not solely a matter of erosion and gravitation, but the cervical abscess was partly formed through the ultimate breaking down of the cervical glands which had become infected.

Mr. C. G. H., age 21, was brought to me by Dr. L. Morris of Salisbury on the 9th of March, 1907. He had just recovered from an attack of influenza and for four days had been suffering intense pain in the left ear. There was no otorrhœa, but the tympanic membrane was congested and bulging. The entire mastoid region was exquisitely tender; over the antrum he could stand pressure of 700 grams and over the tip no more than 300, and there was a small swelling along the posterior borders of the mastoid process. Pus obtained from the middle ear by paracentesis showed pneumococci. Mastoidectomy was performed at once, and in addition to cleaning out the bone cavity a small abscess in the soft tissues just below the tip was evacuated. The superficial glands in this vicinity could be felt, but it seemed probable that they might recover after the removal of the disturbing factor, so they were not exposed. The mastoid wound was closed under blood clot and healed by primary union. At the end of the week, however, it became evident that some of the cervical glands had suppurated, and an incision was made along the posterior border of the sterno-cleido-mastoid muscle to drain them. This proved only partially successful, and on the twelfth day after his admission it was decided to open the posterior triangle of the neck and clean out the disease. The deep, as well as the superficial glands, were found to be involved, and a large amount of pus and debris was removed. The wound is slowly healing, the patient meanwhile having gained sufficient health to permit his return to work.

(*Continued next month.*)

Book Reviews.

Metabolism and Practical Medicine. By Carl von Noorden. Anglo-American issue under the editorship of I. Walker Hall. Vol. I, Physiology of Metabolism; Vol. II, Pathology of Metabolism. Chicago: W. T. Keener & Co. 1907.

No review can do justice to this splendid contribution to the physiology and pathology of metabolism, to the knowledge of which von Noorden and his pupils have added so much during the past few years. The first volume is devoted to a consideration of metabolism under physiological conditions, there being chapters on digestion and absorption, the fate of the food substance in the tissues, the total energy exchange, nitrogenous metabolism, the influence of muscular work and the sexual processes upon metabolism, the rôle of water, the metabolism of mineral substances, and metabolism in old age. None of these articles are by Dr. von Noorden himself; in fact,

they are almost exclusively from the pens of his English students. The subjects are exhaustively considered, brought absolutely up to date, while the bibliography is wonderfully complete.

Vol. II is devoted to the subjects with which the name of von Noorden has always been associated. He himself discusses hunger and chronic starvation, overfeeding and metabolism in diseases of the kidneys, while his German students treat of fever and infection, metabolism in diseases of the stomach and intestines, in diseases of the liver, in diseases of respiration and circulation, and in diseases of the blood. In these articles, again, the subject is treated exhaustively, the bibliography is complete, and we feel that both editors and publishers are to be congratulated for placing such suggestive and stimulating researches within the reach of the English-reading medical public. B.

Physical Diagnosis. By H. S. Anders, M.D. New York and London: D. Appleton & Co. 1907.

This is a very satisfactory presentation of the subject of physical diagnosis. The book is full and up to date, and the subjects are well classified and systematically arranged. The chapter on *x*-ray diagnosis is very interesting, and the illustrations in this chapter as well as in the rest of the book are admirable. The book should prove of real service in the teaching of physical diagnosis. B.

BOOKS RECEIVED FROM MAY 20 TO JULY 17, 1907.

Manual of Anatomy. By A. M. Buchanan, M.A., M.D., C.M., F.F.P.S. (Glas.). Vol. II. Publishers, Wm. T. Keener & Co. Price, $2.75 net.

Around Africa Via Lisbon. By Nicholas Senn, M.D., Ph.D., LL.D., C.M. Publisher, American Medical Association. 1906.

The Efficient Life. By Luther H. Gulick, M.D. Publishers, Doubleday, Page & Co. 1907. Price, $1.20 net.

The Principles and Practice of Dermatology. By Wm. A. Pusey, A.M., M.D. Publishers, D. Appleton & Co. 1907.

The Practice of Pediatrics. By Walter Lester Carr, A.M., M.D. Publishers, Lea Bros. & Co.

The Standard Family Physician. By Prof. Carl Reissig, M.D., and Smith Ely Jellify, A.M., M.D., Ph.D. Vol. I—A to L. Publisher, Funk & Wagnalls Company. 1907.

The Standard Family Physician. Vol. II.

International Clinics. By W. T. Longcope, M.D. Vol. II; seventeenth series. 1907. J. B. Lippincott Company.

Diseases of the Rectum. By W. C. Brinkerhoff, M.D. Publisher, Orban Publishing Co. Price, $2.

The Diagnosis of Diseases of the Nervous System. By Christian A. Herter, M.D. Publishers, G. P. Putnam's Sons. Price, $3 net.

Report on the Origin and Prevalence of Typhoid Fever in the District of Columbia. By M. J. Rosenau, L. L. Lumsden and Joseph H. Kastle. Publisher, Government Printing Office.

Transactions of the American Dermatological Association at Its Thirteenth Annual Meeting. Official Report by Grover W. Wende, M.D., Secretary.

MARYLAND MEDICAL JOURNAL

JOHN S. FULTON, M.D., *Editor*

Associate Editors:

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ROBERT REULING, M.D. | JOSE L. HIRSH, M.D.

BALTIMORE, AUGUST, 1907

MEDICAL EDUCATION IN THE UNITED STATES.

At the recent meeting of the American Medical Association at Atlantic City a very interesting report was made by the Council on Medical Education. It was a wholesome and necessary report, exposing the unsatisfactory status of medical education in the United States. The Council deals rather gently with the delinquencies of American medical schools. It is a temperate report—temperate in the thermometric sense, and not likely to cause energetic reactions or other evidences of healthy stimulation. Still, one can make out from the report that medical education in the United States has improved remarkably in the past 25 years, without having ceased to be rather poor. The Council reports adversely as to both amount and kind of medical education offered to the youth of this country. The situation described reminds one of the experience of a lady who apologized to an unexpected guest by saying at the beginning of a meal, "I'm afraid you will not have a good dinner." "I'm sure," replied the guest, "that your dinner is very good—what there is of it." At the end of the meal the hostess said, "I do hope you have had enough to eat." "Plenty, thank you," the visitor answered—"such as it was." There are in this country 160 medical Almae Matres—as many as in all Europe. Half these schools are properly equipped and the teaching is said to be good. In every ten schools there are three which could teach medicine if they would try, but they do not try. In every five medical schools there is one in which medicine is not taught and cannot be taught. In other words, a young man, choosing his medical Alma Mater, stands an even chance to get a good one. He carries a 30 per cent. risk of being brooded by a negligent and indifferent Alma Mater, and a 20 per cent. hazard of being preyed upon and utterly defrauded by an ignorant and impudent harridan.

The deadly perils of infancy are nothing like so thick-set as the snares which are laid for young men in the way of medical education. The educators themselves offer but an even chance of good training, and when one considers that the young man brings his own adverse chances into the venture, one must expect a mortality like that of abandoned infants. Take the inherent difficulties of the study of medicine. These are fixed charges in the trade of doctor-making. Add 30 per cent. of poor teaching; to this add 20 per cent. of fraudulent teaching; add again the personal infirmities of candidates; finally, make the entrance requirements light, advertise the business and canvass the youth of the country, so that the entry fees will guarantee the management against loss. Now detach yourself long enough and far enough to see the game. A fine and savage educational battue, isn't it? If young men are bundled in and bungled through other sorts of technical education in the same way, the public ought to be advised, for it is just as necessary to have competent lawyers, engineers, undertakers and bellhangers.

THE INFLUENCE OF PUBLICITY.

The Council has allowed its report on medical education to go to the lay press. This was a wise move, and probably a brave one. If it had been announced in advance, vigorous protest would certainly have been heard. The newspapers have not, so far as we are informed, treated the subject in any sensational way. Though a good deal of publicity was obtained, and the report was noticed editorially, no stir has been created, and those who hope to maintain the existing conditions did not receive the shock which they need and fear.

The lay public is not likely to lend a strong hand to the reform of medical education, at least not the hand of chastisement. This task is left to the medical profession. The appeal to popular intelligence for laws on medical practice and for the financial support of medical education may seem overlong unheeded, but the progress of the last 20 years is, after all, extremely gratifying if one considers the pit from which we were digged in that period. Medical examining boards perhaps have not, as a rule, reached a high grade of efficiency. Some of them doubtless are, as the Council says, merely political machines; but medical examining boards have come into existence in response to the demand of the profession, and their average of efficiency, being controlled by the status of medical education, is quite as good as we could reasonably expect. The financial support accorded to medical schools, and particularly the private endowments, may not, as the Council says, bear a satisfactory relation to the support enjoyed by other technical schools and by schools of theology and of the liberal arts, but the medical departments of many State universities get sufficient funds from the State treasuries, and a few States deal with their medical schools so liberally as to have excited the envy of other university departments. Private benefactors have not quite overlooked the claims of medical education, though they have been more generous toward advanced than toward undergraduate medical study. In the past 10 or 15 years enough money has been invested in medical education to create between the proprietary and the university schools of medicine a deep and dismal chasm. The proprietary schools which can cross this gulf are few, and for those which cannot the situation is desperate. Some seem to think that this profound cleavage leaves the universities on the safe side, and there is a kind of scramble for university affiliation. But the fact is that every sort of education has grown more expensive, and some of the combinations effected signify only the union of several painful uncertainties.

One must regret that the improvement cannot be general, but that is an extravagant regret. The country is passing rapidly out of conditions in which imperfect methods of education were tolerated, if not quite necessary. A natural and inexorable economy has drawn this line of demarcation between the elect and the doomed. It is not a pleasant thing to contemplate. It contains an element of cruel surprise and seems more drastic than nature's processes usually are.

One may inquire whether the Council should not have printed the names of those 32 schools which are schools in name only. They exist only as traps for young men, and surely the highway of learning should be cleared of such dangers. There is no need of a written law to suppress nuisances of this sort. Publicity will do it.

SUNDAY SODA.

BALTIMORE is now having a mild spasm of Sunday virtue. The clubs cannot serve liquor to their members on Sunday, barber shops are liable to Sunday raids, and the soda fountain has been threatened with Sunday rest. So far as the law is concerned, there is no doubt that Sunday shaves and Sunday sodas are obtained in violation of law. But the customer incurs no liability; the vender carries all the risk of prosecution. It is a negligible risk, however, for the quality of these offenses does not move grand juries to action. Information, even when furnished by police departments, lies dormant and barren in the chamber of grand inquest.

The recent agitation against the druggists' sales of cool drinks on Sunday has not in the least curtailed the privileges of the thirsty public. At all events, one may observe that here and there a confectionery or a pastry shop has of late been open regularly on Sunday and selling soda water. If the Sunday traffic in soda water should extend to all the shops which now sell soda on week-days, the situation would be interesting. The druggists have only the advantage that the sale of sickroom requisites on Sunday is lawful, and drug stores are lawfully open on Sunday, while other shops, having no commodity lawfully salable on Sunday, would violate the law in the act of opening the shop. Hitherto the druggists have enjoyed a considerable advantage in their monopoly of the Sunday soda business. Whenever these unlawful sales are under fire the druggist's main plea rests on the necessity of open pharmacies for the sake of the sick. The Sunday soda business, they say, enables them to supply the sickroom. Without the Sunday sales which are unlawful the lawful business of Sunday would result in loss and must be suspended. This result would undoubtedly follow in many instances, but the reach of this argument does not stop at Sunday business. Here we find a substantial reason for limiting the privileges of druggists. Miscellaneous merchandizing has a corrupting influence on the business of pharmacy. Profitable side lines, and the beverage business especially, not only depreciate the pharmacist's professional efficiency; they bring into existence drug shops which are not needed, and which are not helps, but hindrances, to the sick in the neighborhood. Many of these stores cannot and do not supply the needs of physicians and nurses either well or promptly. Their pharmacies are not properly stocked in the first place, and not punctually replenished in the second place. Such shops often satisfy customers with plausible subterfuges. For instance, a prescription for salicylate of soda in five-grain tablets may be received. "It will take about half an hour to *prepare* this," the clerk says, and the customer is satisfied. The preparation consists in sending a messenger out for 500 or 1000 tablets, and sending the 30 tablets required to the customer's house. There are drug stores where the soda fountain and tobacco stand are always well stocked, while the pharmacy does a kind of commission business. It is an easy game, for the average citizen does not discriminate as well among druggists as among physicians. To be sure, this sort of pharmacy injures the business of pharmacists having real professional ability. The existence of many such druggeries is detrimental to a dignified and responsible calling, and no matter how serviceable such shops may be to the well and thirsty, they are negligent and incompetent servants of the sick, in whose interests they are especially privileged to do business on every day and at all hours throughout the year.

Medical Items.

BALTIMORE.

Among the Baltimore physicians now in Europe are Dr. H. B. Jacobs, Dr. John Ruhrah, Dr. W. G. MacCallum, Dr. J. Frank Crouch, Dr. H. O. Reik, Dr. W. W. Ford and Dr. Jos. T. Smith.

Dr. J. H. Hartman had a narrow escape recently while motoring on South Mountain. The brake of his automobile failed while he was descending a steep grade. Dr. Hartman was thrown out and seriously bruised.

The specially-chartered steamer for the use of the Medical and Chirurgical Faculty during the semiannual meeting at Jamestown is a particularly attractive arrangement. The attendance should be large.

Dr. Howard A. Kelly is at his hunting lodge in Canada; Dr. L. McLane Tiffany is at Manchester-by-the-Sea, Mass.; Dr. C. A. Penrose is at Nantucket; Dr. H. Warren Buckler is at Jamestown, R. I.; Dr. Edward Mellors is at Dublin, N. H.; Dr. John W. Chambers is at Mt. Clemens, Mich.

The organization of the International Congress on Tuberculosis is making good progress. The Congress will be divided into seven sections, as follows:

Section I.—Pathology and Bacteriology—Dr. Wm. H. Welch, president; secretaries, Dr. Wm. R. Stokes and Dr. Harold C. Ernst.

Section II.—Clinical Study and Therapy: Hospitals, Dispensaries and Sanataria—Dr. Vincent Y. Bowditch, president.

Section III.—Surgery and Orthopedics—President, Dr. W. J. Mayo.

Section IV.—Tuberculosis in Children: Etiology, Prevention and Treatment—Dr. Abraham Jacobi, president.

Section V.—Hygienic, Social, Economic and Industrial Relations of Tuberculosis—Mr. Edward T. Devine, president.

Section VI.—State and Municipal Control—Surgeon-General Walter Wyman, president.

Section VII.—Tuberculosis in Animals and Its Relations to Man—Dr. Leonard Pearson, president.

State committees are being formed for each State in the Union, and foreign committees are also being formed. A prize of $1000 is offered by the Congress committee for the best evidence of effective work done by any voluntary association in the prevention of tuberculosis since the last Congress, in 1905. Other prizes will be announced later.

MARYLAND.

Dr. W. D. Corse of Gardenville, Md., was struck by lightning during the severe storm of July 18. He was rendered unconscious, but recovered.

GENERAL.

The winner of the Alvarenga Prize of the College of Physicians and Surgeons of Philadelphia for the year 1907 is Dr. Wm. Louis Chapman of Providence, R. I., whose essay was entitled "Post-operative Phlebitis, Thrombosis and Embolism."

The Mutual Life Insurance Co. of New York and the Equitable have restored their examination fees to the old figure, $5. This action has resulted from the vigorous and determined protest made by the medical profession.

Owing to the fact that it is now considered that rubber containing antimony is not dangerous to health, the German Government has rescinded a former measure making it unlawful to use rubber of this sort in connection with containers of foodstuffs.

The Central and Federated Union of Coopers of New York, at a meeting last week, passed a resolution expressing its disapproval of the practice of certain "soulless individuals" who are alleged to buy for three and five cents the garbage barrels emptied at the New York dumps, repair them, and use them again for the packing of meat, vegetables, flour, etc., for public consumption. Copies of the resolution have been sent to Health Commissioner Darlington and Mayor McClellan.

Chicago made very elaborate preparations for the patriotic sacrifices on July 4. The newspapers spread information about the dangers of explosives and about the fatal possibilities of slight-appearing wounds. Twenty-six senior students of the two chief medical schools formed a volunteer corps for the aid of the injured. The Health Department mobilized its whole ambulance and hospital service and provided tetanus antitoxin. And then the Fourth of July casualties were very much fewer than for many years past. The elaborate preparations seem to have been unnecessary. That is the way to prepare—so well that the emergencies expected will not materialize.

Preparations on this scale cut down the casualties. Bully for Chicago!

Passengers arriving in New York from Cuba now have their temperatures taken at quarantine, and if thought advisable are kept under observation for a day or two at Hoffman Island. An arrangement has been made in Havana, under the sanction of the United States Marine Hospital Service, to enable passengers to the Southern States to avoid detention on landing by spending several days under observation in a quarantine camp before sailing. It is planned to centralize the sanitation of the whole island under Major Kean, United States sanitary supervisor.

The third International Sanitary Convention is to be held in the City of Mexico on December 2 to 7 of this year. The two preceding conferences were held in Mexico in 1902 and in Rio Janeiro last year. The program provides that each delegate shall bring a paper relating to the nation he represents and covering a report on the existence of transmissible diseases that may prevail in its territory, especially with reference to bubonic plague, yellow fever, cholera, malaria, beriberi and trachoma. A request is made for information as to the methods adopted for the prevention and stamping out of such diseases; also reports on the condition of ports and sanitary police laws. The transmission of yellow fever and the means to be used in combating the stegomyia mosquito, the tuberculosis question and various administrative measures will also come up for discussion. Surgeon-General Walter Wyman is chairman of the International Sanitary Bureau.

The Southfield, one of the old ferryboats of the Staten Island line, which has been put out of commission by the newly-constructed municipal boats now running to that point, has been placed by Commissioner Benzel of the Department of Docks and Ferries at the disposal of the committee on tuberculosis of the Charity Organization Society. The boat is a large one, with double decks, and it has been fitted up as a tuberculosis camp, with hammocks, steamer chairs, etc. A trained nurse is in attendance, and once a week the committee meets on the boat and the medical members of the committee serve each two weeks in turn as visiting physicians. The patients who are sent from the various dispensaries of the city spend the day in the fresh air, and in the evening, with the exception of a few male patients, who remain all night on board, are dismissed to their homes. Each receives from three to eight eggs and from three to eight glasses of milk daily, and at noon a meal, consisting of bread and butter, hot tea or coffee and a cooked egg, is served. In addition, the patients are permitted to bring with them whatever food they choose. Although this undertaking has been but a short time in operation, the results appear to have been very satisfactory. A member of the committee in speaking of them recently said: "The patients are putting on pounds and the color is coming back to whitened cheeks in a wonderful manner. Now and then a good friend sends us some fruit, magazines or flowers, and with these and the extra diet and fresh air, our patients are getting along famously."

A meeting of professors of pediatrics and hospital clinicians in that branch was held at the Marlborough-Blenheim, Atlantic City, June 3. Many of the best-known pediatricians of this country were present. A very successful meeting was held, and a permanent organization was effected which bears the name "The Association of American Teachers of the Diseases of Children." Professors, associate professors and lecturers in medical colleges of the United States, Canada and Mexico are eligible, also hospital and dispensary staff members actively engaged in treating children. The principal objects of the organization are to advance the study of children and their diseases and raise the standard of the teaching of pediatrics in medical colleges and its practice in hospitals, dispensaries and private practice. The association elected the following officers: President, Dr. Samuel K. Kelley, professor diseases of children, Cleveland College of Physicians and Surgeons, Medical Department of Ohio Wesleyan University; vice-president, Dr. Charles Douglas, professor diseases of children and clinical medicine, Detroit College of Medicine; secretary, Dr. John C. Cook, professor diseases of children, Post-Graduate Medical School and Hospital of Chicago; treasurer, Dr. George H. Cattermole, professor diseases of children, Colorado School of Medicine; senators, Dr. W. C. Hollopeter, professor diseases of children, Medico-Chirurgical College of Philadelphia; Dr. H. M. McClanahan, professor diseases of children, University of Nebraska College of Medicine, Omaha; Dr. R. B. Gilbert, professor diseases of children, Louisville University, Medical Department.

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THE DUTY OF THE PUBLIC TOWARDS THE TRAINED NURSE.

By Wm. Royal Stokes, M.D.,

Baltimore, Md.

READ AT THE GRADUATING EXERCISES OF THE TRAINING SCHOOL FOR NURSES AT THE CITY HOSPITAL, JUNE 18, 1907

It has been well said that the profession of nursing began with the Christian era. Before this time certain Jewish women were organized into societies for caring for the sick, and the Druids of Gaul had women who nursed ill persons. These well-disposed persons were sometimes considered to be witches, and were destroyed by fire and other forms of execution. The profession thus became rather unpopular and finally disappeared.

The system of trained nursing seems to have received a great impetus from St. Paul, and the Acts of the Apostles and the Epistles contain accounts of many devoted women who gave up much of their time to nursing the sick. These women combined the duties of the religious teacher, the social worker and the trained nurse in one profession. Dorcas, "this woman full of good works," and "Phoebe our sister," commended by St. Paul, with many others, must have often ministered to the sick in that interesting community of the early Church.

St. Paula, a noble lady of Rome, being left a wealthy widow, gave both her money and time to nursing during the fourth century at Rome, and later at Bethlehem she organized an order which cared for sick pilgrims.

Such communities were soon recognized as most beneficial, and about 660 A. D. the Hotel Dieu was established at Paris as a large hospital. The hospital sisters, or "Soeurs Hospitalières," performed the office of nursing in this institution, and Sarah Tooley in her "History of Nursing" tells us that they remained for 500 years the only organized nursing sisterhood in a large hospital.

Thus the idea of trained nursing was kept alive through the centuries. In the first school for trained nurses, established by the Abbess Hildegarde near Bingen-on-the-Rhine, the nuns were instructed in the use of drugs. They also obtained practical work in the convent infirmary established for the poor. The Knights Hospitallers, or Knights of St. John, established a hospital in Jerusalem, in the eleventh century, to care for the sick pilgrims, who often reached the Holy City ill and poor or wounded by the robbers on the way. The ill-treatment of these pilgrims led to the various crusades. The Knights of St. John soon became a fighting organization, and took part in many battles for the defense of the Holy Land against the Mahometans. They formed an organization of brothers and sisters, who nursed the sick and homeless in St. John's Hospital at Jerusalem. Hospitals were also founded in many European and Asiatic cities, along the routes of pilgrimage, and this powerful society remained for centuries the great hospital order of Europe.

We cannot approach modern times without mentioning the splendid work of Saint Vincent de Paul, the shepherd boy, who became one of the most famous priests and philanthropists of his time. In 1617, at Lyons, he organized his well-known order of Sisters of Charity, which at Paris in 1633 developed into the Sisters of Saint Vincent de Paul. Many rich and famous women joined this order, and in 20 years over 200 homes and hospitals belonging to this organization had spread over Europe. They not only nursed the sick in hospitals, but were expected to care for the suffering in every town and every land. A modest dress and headgear were designed, and the good old saint showed his knowledge of the eternal feminine when some of the more worldly suggested that the dress might be changed to suit different places. "No," said he; "they will have as many different hats and bonnets as there are cities and countries." And so today the ever-welcome garb of the Sister of Charity is the same "in Greenland's icy mountains" as "on India's coral strands." From now on we have the nurse visiting the sick in their homes, and this order has founded over 2000 houses, with many hospitals, orphanages and schools, throughout the world. This society also brought the trained nurse out of the cloister and hospital into the outside world and thus greatly broadened the scope of such humanitarian work.

It is hardly necessary to mention the nursing sisters of the twelfth century attached to St. Bartholomew's and St. Thomas' Hospital in London, since they were driven away with the general dissolution of the monasteries by Henry VIII in 1525. Nursing in England received its quietus for several centuries, and was only revived by the epoch-making struggles of Elizabeth Fry. This energetic woman was born in Norwich in 1780, and her family had been Quakers for generations. After a girlhood spent in frivolous pursuits, she began earnest philanthropic work and accomplished many important prison reforms. In 1840 she visited Pastor Fliedner at Kaiserswerth, and became so much im-

pressed with the training school for nurses at the Deaconess Hospital that she took steps, upon returning to England, to establish a religious institution for training nurses. These nursing sisters lived in a special home, but were trained in the hospitals. When their probation was over they were allowed to nurse in hospitals or private homes, and received remuneration according to the ability of the patient or family. They were all compelled to spend part of their time in the gratuitous nursing of the sick.

Most of us have doubtless enjoyed the humor of Dickens as expressed in his character of Sairey Gamp.

" 'Mrs. Gamp, if ever there was a sober creetur to be got at eighteen pence a day for working people, and three and six for gentle folks, you are that person.'

" 'Mrs. Harris, I says to her, don't name the charge, for if I could afford to lay all my fellow-creeturs out for nothink I would gladly do it, sich is the love I bears 'em.' "

These character studies in Martin Chuzzlewit focussed public attention upon the crudities of nursing and helped to advance the profession to its present well-organized condition.

Many important advances followed this arousing of public sentiment. King's College Hospital, in 1856, instituted a training school for nurses and admitted the sisters of the famous St. John's House to training. The conditions revealed in the hospitals at this time were serious, although not without their humorous side. Nurses of the Sairey Gamp type were frequently dismissed for drinking the patient's brandy, wrapping up in a patient's blanket for a quiet nap at night, returning to the ward at night drunk and disorderly, and for many other grave breaches of discipline and morals. Imagine, young ladies, if you can, the tapman from the neighboring barroom passing through your ward twice a day to receive your order for ale, porter or brandy. These and many other bad practices were stopped when training schools were added to the large London hospitals. Contagious diseases were separated from non-contagious conditions, baths and open windows were introduced, and sick diet became a regular part of treatment in the wards.

In a consideration of the evolution of trained nursing the work of Pastor Fliedner cannot be omitted. This Lutheran clergyman, after many severe struggles, succeeded in establishing a small hospital at Kaiserswerth, a village on the Rhine in Germany. The nursing was carried out by deaconesses, and from this small "Mother House," with two deaconesses and one patient, a system developed which included 100 similar institutions in all parts of the world. Kaiserswerth, in addition to a large hospital and training school for nurses, also soon included an orphanage, a school for girls, a female house of refuge, a normal school and many other philanthropic institutions. It has furnished thousands of nurses to many hospitals in all parts of the globe, and its most famous pupil was Florence Nightingale.

Miss Nightingale was born near Florence in 1820, but spent most of her time in England, where her family had lived for generations. Her life as a girl and young woman at Lea Hall and Lea Hurst in Derbyshire was filled with many charitable deeds, and she became very much interested in the hospital system in Great Britain. While carrying on these investigations she met Elizabeth Fry, who persuaded her to visit Pastor Fliedner at Kaiserswerth.

This well-born and highly-cultivated young English woman entered Kaiserswerth Hospital as a nursing deaconess when many considered such work beneath their dignity. She endeared herself to all about her, and left the institution after a thorough course in hospital nursing. After studying with the Sisters of St. Vincent de Paul in Paris, she returned to England and immediately began a life of philanthropy in London. Here she helped to organize schools for poor boys, children's hospitals, emigration bureaus for poor women, homes for sick governesses and other similar institutions.

In 1854 the Crimean War began, and from the very center of this struggle Florence Nightingale received the call for her life-work. Although victory followed the English arms, yet the enthusiasm of conquest was tempered by the news of the frightful condition of the sick and wounded. Food, clothing, medicines, bandages and other necessities were all wanting. There were not enough physicians and no nurses for the English soldiers. It was at this time that the "one clear call" came for Florence Nightingale. Russell, the war correspondent, wrote: "Are there no devoted women among us, able and willing to go forth to minister to the sick and suffering soldiers of the East? * * * Must we fall so far below the French in self-sacrifice—in a work which the Master so signally blesses as done unto Himself?—'I was sick and ye visited Me.'"

Miss Nightingale immediately responded and organized her celebrated band of nurses for the military hospital at Scutari, near Constantinople. This band consisted of 14 Church of England Sisters, 10 Catholic Sisters of Mercy and 14 nurses from various other sources. The leader was made lady-in-chief in charge of all the hospitals. Shocking conditions were found at these hospitals—no beds; men lying for weeks in uniforms still stained with blood from their wounds; no soap, towels nor vessels for water; no kitchens or culinary utensils, and no sheets, drugs or medical supplies. Cases of cholera, of plague, of hospital gangrene lay side by side with the wounded on the floor of the hospital at Scutari. These conditions were slowly but surely remedied, but before peace was declared the lady-in-chief contracted hospital fever and nearly died. After the war was over she remained until most of the wounded were safely shipped to England.

The rest of the life of Florence Nightingale is intimately associated with almost every philanthropic reform in England, but one of the most important was the founding of the training school for nurses at St. Thomas' Hospital in London, 1860. Other hospitals later followed suit, and the modern training school for nurses dates from this era.

If time permitted we would consider many other important reforms instituted by Florence Nightingale and her followers, but I can only mention the introduction of trained nurses into military and naval hospitals and institutions for the insane as due to her pioneer work.

The Poor Law Nursing Service was also greatly improved by the substitution of trained nurses for pauper, inmate and feeble and aged attendants, and many cases of shameful abuse and neglect were corrected by the untiring work of Louisa Twining. The establishment of various associations for private nursing, the institution of district nursing by Mr. William Rathbone, the struggle for registration of nurses and the general recognition of nursing as a special profession are all interesting, but I must close this part of my subject with a brief consideration of our own workers in this cause.

It is customary to commend persons after their death, but I can see no reason why I may not mention the names of a few of our local workers while they are still with us. Due credit should be given to Miss Nutting for her admirable work in advancing our American profession of trained nursing, and she will still continue to add valuable contributions from her professorial chair at Columbia University. Miss Ross is ably continuing her work at the Johns Hopkins Hospital, and Miss Flanagan of the University Hospital, and many others are helping to elevate the standards of this profession in Maryland. I cannot close this subject without expressing my great respect for the work of two other women in our community—one the lifelong friend of my grandfather, and the other, I hope, my own. I refer to Sister Catherine of Mount Hope Retreat, and Sister Carmalita, the Sister Superior of our City Hospital.

And what do we owe to this profession and to these women? I shall answer with brutal frankness: we owe them money.

It is almost unnecessary to mention the various things which are needed in a large hospital. Beds endowed, new wards opened, instruments of special precision in these wonderful days of modern medicine are all thoughts which at once arise. Pensions for disabled or sick nurses, libraries, special courses and many other needs might also be recognized. Go and discuss these matters with a sister or trained nurse for 15 minutes, and if you do not leave them with an empty pocketbook you are "fit for treason, strategy or spoils; let no such man be trusted."

But there is a special piece of work which especially commends itself to me at this time, and this is the reorganization of the out-patient departments or the dispensaries of our hospitals. The pioneer in this work is Richard C. Cabot, and his article in the MARYLAND MEDICAL JOURNAL for March, 1907, describes the great work that he has accomplished in Boston.

He aptly emphasizes the present condition of affairs by the quaint quotation from "Alice in Wonderland:"

"'Have some wine,' said the Hatter.

"'I don't see any wine,' said Alice.

"'There isn't any,' said the Hatter.'"

As Cabot says, we tell patients to get a new position, a vacation, an expensive splint, a change of climate, and we might as well tell them to get a million dollars. Like the Hatter, we invite them to have some wine, and there is no wine.

It seems to me that a general society called a dispensary society might well help to solve the many serious problems that arise in the various dispensaries. Representatives from all of the hospitals might accomplish more good in one large society than smaller local organizations. Such a society, as pointed out by Cabot, by soliciting subscriptions might furnish special workers and apparatus for many nervous cases, might provide for massage and administer the hydropathic cures by skilled operators. They would follow many patients to their homes, perhaps remove serious sources of worry, and might save many lives by properly instructing consumptive patients in the prevention and cure of this disease. Proper cases would be sent to sanatoria for treatment, and district nurses could find many needy cases if directed from such a central source. Patients with diabetes could be provided with proper diet, milk could be modified for children, and, in fact, the dispensary might be made a general clearing-house for the alleviation of many grave and even minor ills.

In order to properly carry out these methods Cabot believes that a few skilled physicians and social workers should be paid for their work, as he thinks that this is just as important public work as that of the department of health or charities and corrections.

He found that 37 per cent. of the cases at the dispensary of the Massachusetts General Hospital were cases of purely functional disorders which might be better treated by the methods outlined above than by the wholesale and often useless drugging so prevalent at present in our dispensaries. Many organic diseases, such as tuberculosis in its various forms, and surgical diseases also, often need other aid than that of medicine or of the surgeon's knife.

But why continue this discussion any further? The kind hearts of the women here present have doubtless already solved some of these problems while I have been talking about them. Why not form such a society as I have merely briefly outlined?

REPORT OF A CASE OF ADAMS-STOKES DISEASE.*

(General Infection; Bradycardia; Epilepliform Seizures; Cheyne-Stokes Respiration; Apparent Recovery)

By T. F. Leitz, M.D.

H. M., white, married, laborer, aged 51. Entered the hospital October 23, 1906, in the service of Dr. Gamble. His father, mother and one sister died of tuberculosis. Apart from this, there was nothing of interest in his family history.

His own personal history is particularly clear, giving no history of syphilis, alcoholism or of any infection.

He came into the hospital on account of pain and swelling in his right wrist, associated with attacks of vertigo, the latter appearing about two weeks in advance of the former.

Physical Examination.—He has an emaciated appearance, lies in bed and takes no notice of the surroundings. The skin is dry and loose; mucous membranes are anemic; expression is dull and apathetic; pupils are equal and react to light.

The arteries are slightly sclerosed. The radial pulse is 15 per minute, is of low tension, easily compressed and of good volume. Venous pulsations are marked in the neck, counting about 84 per minute, being suggestive of complete heart-block. To the right and left of the sternum at third rib are two dilated veins which pulsate. The rate here is synchronous with the pulsations in the veins of the neck; rate 84 per minute.

The heart extends from the third rib above to the sixth rib below. The apex beat is in the sixth interspace below and to the left of the nipple. It is irregular and heaving. A systolic murmur is heard at the apex. The aortic second sound is accentuated and the pulmonic second is not distinct. The lungs, abdomen, spleen and liver are negative, but the blood pressure is low—95 mms. of mercury (Riva-Rocci).

The blood examination showed 19,800 whites and 3,964,000 red. On changing from recumbent to sitting posture there is no change in the radial pulse.

Course of Case.—The pulse increased in frequency, volume and tension as his general condition improved. The increase was from 15 to 50 beats per minute on the 15th day. During the first three days in the hospital the patient had epileptiform seizures, Cheyne-

*From the Department of Medicine of the College of Physicians and Surgeons, Baltimore, Md.

Stokes respirations and periods of mental aberration, these attacks being of short duration and at irregular intervals, but not frequent. On the fifteenth day the radial pulse skipped every third beat, returning to the regular rhythm on the next day. The swelling in joints diminished, and there were no more of the above attacks after the third day.

The patient left the hospital on November 20, apparently cured, and at present is working.

The treatment consisted of complete rest in bed and potassium iodide in increasing doses until 20 grains were reached, three times a day. The case is undoubtedly one of Adams-Stokes disease, presenting the three cardinal symptoms as given by Ashton, Norris and Lavenson in their late work—(1) bradycardia, (2) cerebral attacks and (3) pulsations of the cervical veins exceeding in rate the arterial pulsation.

There was present an infection the nature of which, unfortunately, was not determined. The case was very interesting, coming under observation at this time when a vast amount of work is being done by recognized physiologists on this side and in Europe on the cause and changes taking place in this alteration in the circulation. It is produced, as is thought at present, by some pathologic change in the only demonstrable muscular connection between the auricles and ventricles through which the stimulus passes and which was first described by Kent and His in 1893.

In 1905 Tawara gave a minute description of the anatomy of this bundle. Retzer, Breunig, Humblet in Europe and Erlanger and a few others in this country had devoted much time to this bundle and have gotten brilliant results. By ingenious contrivance Erlanger produced heart-block in a dog. He increased the intersystolic period by gradual compression with a clamp on this muscular bundle, lengthening the interval according to the amount of compression employed. By keeping up the pressure until the auricular impulse fails to pass the obstruction complete heart-block was produced. Furthermore, he demonstrated that when complete heart-block was produced the vagus lost its influence over the ventricle, but not the auricle. This explains in our case why there was no change in the pulse-rate when the patient was changed to a sitting from the recumbent posture. The lesson to be taken from this case seems to be the apparent recovery (patient at present is working) following such a typical case, which can be attributed to either a regeneration of the bundle of His, which probably was affected, or the taking on of an automatic power of originating ventricular contraction, as stated by Keith and Miller, or perhaps there is some other connection that transmits the impulse which at the present time is not demonstable.

AN APPEAL TO THE AMERICAN MEDICAL PROFESSION.

By S. A. Knopf, M.D.,

New York.

On May 8, the day following the meeting of the National Association for the Study and Prevention of Tuberculosis, there appeared in the *North American* of Philadelphia a most sensational article by Mr. Richard J. Beamish, according to which, during the discussion of Dr. Flick's report on medication, I was reported to have advised the killing of dying consumptives quickly and painlessly by heavy doses of morphine, and to have admitted that it was my daily practice to do so. It was furthermore said in this article that there had been a bitter debate and that the session adjourned in confusion. These false statements were copied by nearly all the newspapers in the United States, were cabled to Europe and made the rounds in the papers and magazines of England and the whole European continent. In spite of explanations and denials I had sent to the Associated Press, in spite of a strong letter written by Dr. George Dock, the presiding officer of the meeting and sent to the leading medical journals of America giving the true version of my remarks, the false statement has continued to be published and republished and commented upon to the great detriment of the anti-tuberculosis crusade all over the world. For example, ignorant consumptives in St. Louis who had read the sensational lie refused the visit of the nurses sent to them by the Society for the Relief and Prevention of Tuberculosis. The St. Louis *Republic,* which pubished this news item, said: "Consumptives since they read that report apparenty have a dread that the visit of the nurse may mean morphine to end their suffering." It became thus necessary to issue the following statement by order of Prof. Frank Billings, president of the National Association for the Study and Prevention of Tuberculosis:

"Various daily newspapers published on May 8 what purported to be a report of the remarks of Dr. S. A. Knopf of New York before the National Association for the Study and Prevention of Tuberculosis, in which he was made to say: 'It is my practice and your sacred duty when you see a dying consumptive before you

to give the sufferer morphine in plenty, that the end may come quickly and painlessly.'

"No such statement was made by Dr. Knopf, but since, in spite of an immediate explicit denial by the Doctor, a great many newspapers in this country and Europe continue to publish the false report as authentic news, Dr. Frank Billings of Chicago, president of the National Association for the Study and Prevention of Tuberculosis, authorizes the following statement:

" 'Quite apart from the false position in which the speaker was placed and the injury done him, the publication of such a piece of sensationalism cannot fail to have a very deleterious effect upon impressionable tuberculosis patients throughout the country, and may keep others from seeking needed medical aid.'

"The following statement made by Prof. George Dock of the University of Michigan, who presided at the meeting in which Dr. Knopf spoke, should preclude all further misunderstanding:

" 'I heard clearly what Dr. Knopf said. I am sure that I know what he meant, and I am sure that everybody in the room must have understood what he said. His words could not possibly be converted into the meaning given in the public press. It was perfectly clear that he meant to relieve patients in the last stages. Everybody knows this prolongs life, while making it very much easier for the patient.'

"LIVINGSTON FARRAND,
"Executive Secretary."

I had hoped that this statement would put a stop to all further comments on and circulation of the sensational falsehood. I am free to confess that I have longed for the time when the lie would die out, for, in spite of the loyalty manifested by my professional friends during these hours of trial, for which I beg them to accept my most heartfelt thanks, the ordeal had become almost unbearable.

It seems that such a lie dies hard and from time to time receives a new stimulus from the overzealousness of some physician or layman. Thus, for example, through the courtesy of Dr. George H. Simmons, the editor of the *Journal of the American Medical Association*, I received a copy of the Kansas City *Journal* of last week, containing an editorial under the heading "Should Doctors Kill?" from which I quote the following:

"The question whether a physician is justifiable in shortening the life of a patient suffering from an incurable disease by administering anesthetics was given a fresh impetus recently by the declaration of Dr. S. A. Knopf before the Tuberculosis Congress in Washington, advising that consumptives should be given heavy

doses of morphine to hasten the end. To the credit of the profession it must be said that physicians generally repudiate the idea as atrocious and a violation of medical ethics. A Chicago physician, Dr. Charles Gilbert Davis, voiced this sentiment, saying: 'A physician who would make a statement of that sort should be taken out and hanged. The profession has not gotten so low that it must commit murder just because it has not yet discovered a cure for some disease. There is nothing incurable under the sun. Just because the cure has not been discovered that does not mean it never will.'"

In Dr. Dock's letter above referred to, as well as in the statement authorized by Dr. Frank Billings, the absolute falsehood of the respective newspaper report was clearly shown, and it would seem that there was hardly an occasion for Dr. Davis to unburden his feelings for the benefit of the lay press.

Equally untrue was the report of the alleged "adjournment in confusion" and the "lively and bitter debate" which followed Dr. Flick's report condemning the use of morphine and its compound. In refutation of this reflection made by Mr. Beamish on a body of scientific men, composed of many of the leading American physicians who have devoted their lives to the study and prevention of tuberculosis, permit me to publish for the first time an extract from a letter which was received recently by Dr. Joseph Walsh, the secretary of the section:

"I was present as secretary of the section at which you spoke, and instead of the section breaking up in confusion, as was stated in the newspapers, the section closed in the perfectly regular way, and your statement as generally understood by the medical men seemed to be generally agreed with."

I beg the medical press of the United States to copy this communication in the hope that it will help individual members of the profession to refute once for all the inconceivable proposition that any physician true to his calling could possibly propound such a doctrine as shortening the life of any patient entrusted into his care. To the individual members of the profession in this country and abroad I address a personal appeal to embrace every opportunity to disabuse any individual who may labor under the misapprehension that I or anybody else of the American medical profession recommended shortening the lives of consumptives or any others by the administration of chloroform, morphine or similar narcotics. I make this appeal not merely for my own sake, but, above all, for the sake of truth and for the sake of consumptive sufferers in this and in other countries.

Society Reports.

THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY.

MEETING HELD APRIL 15, 1907—DR. NORTON IN THE CHAIR.

(Continued from last month.)

Case 3. As an example of what pus does when it seeks an outlet from the mastoid by creeping upward and forward, I am permitted to recite a most interesting and remarkable case. The patient can say that he has suffered much at the hands of many physicians, and if his history demonstrates anything more strongly than the point I wish to lay before you it is that some persons are extremely hard to kill.

J. R., 27 years of age, came to the Hopkins dispensary February 5 complaining of earache and a painful, fluctuating swelling above and in front of the auricle, extending down on the cheek to a level with the tragus and forward to the frontal eminence of the malar bone. There was practically no swelling back of the ear, but a great deal of tenderness over the mastoid antrum. The external auditory canal contained much pus, and its posterior-superior wall bulging, an unfailing sign of mastoiditis. He had not slept for several nights, and on account of the facial swelling could open his mouth barely half an inch. His temperature was 100.6 F., pulse 84, hemoglobin 95 per cent, leucosytosis of 13,000, and the pus from the ear showed diplococci. His trouble began on the 18th of December, 1906, and on Christmas day he had a severe earache. His family physician applied a fly blister over the mastoid and gave him some internal medicine, but this treatment did not give relief. After three weeks devoted to the use of salves in and behind the ear and the taking of much medicine, spontaneous rupture of the tympanic membrane occurred, and, with the profuse otorrhea that followed, he secured some relief from pain. The flow of pus alarmed him, however, and he visited a dispensary in the neighborhood of his home, where he was advised to irrigate the ear with a solution of boracic acid. As he did not take a fancy to the assistant at that hospital, he did not return, but instead, some days later, consulted a physician who had a dispensary in connection with his office. From the middle of January to the middle of February he continued under this man's care. The treatment consisted mainly of pills, and he says that at one time he was taking as many as three different kinds of pills a day. As the facial abscess grew in size the skin became tense and the pain increased until he was in agony. He pressed the physician for a diagnosis, and on being told that the trouble was mumps left in disgust, remarking that he knew better than that himself.

At operation the mastoid cortex presented an ivory-like density, the internal structure was completely necrotic, and the invasion of the face had resulted from extension through cellular structure in the posterior root of the zygoma, with perforation above the glenoid fossa. Fifty cc. of thick

yellow pus was evacuated from the cheek, and it became necessary to make a counter-puncture in the cheek in order to properly drain the abscess cavity. In two weeks the patient was allowed to leave the Hospital, mastoid wound being nearly closed and the facial abscess only requiring occasional dressings. His misfortunes were not at an end. In about two weeks he returned to the Hospital with facial erysipelas, which proved to be of a virulent type, and from which he probably would not have recovered had not anti-streptococcus serum been used.

Case 4. This, the last case, deals with a purulent invasion of the cranial cavity from the middle ear. On the 20th of March, 1907, I was asked by Dr. Frank Smith to see a little girl nine years of age who had just recovered from an attack of measles and whom he suspected had otitis media. Dr. Smith had seen the case for the first time only that morning. Throughout the attack of measles the child had complained more or less of earache on the right side, but as she had frequently suffered from this trouble before, no attention was paid to it. During the night of March 19 earache increased, and she had frequent spells of vomiting. When I saw the patient, P. M. March 20, she was complaining of a severe diffuse headache, and whenever she attempted to raise her head vomited a clear greenish-colored fluid. The temperature was 102 degrees F. at that time, and the right tympanic membrane was yellow and bulging into the canal. A paracentesis was immediately performed under chloroform. The tenderness over the mastoid was at this time so slight as to make it appear that it might be entirely due to otitis media.

At nine o'clock that night I was told that the child was having convulsions and was unconscious. Dr. Smith, who saw the third convulsion, said that there was nothing characteristic about this or the next one. The fifth, which we observed together, was a typical Jacksonian convulsion of the opposite side, first a twitching of the lips, then the left side of the face, the left arm and leg, with a flexure of the leg upon the thigh and the thigh upon the abdomen, and then subsidence. Both eyes were turned to the right throughout the spasm. The convulsions then followed one another almost without intermission until midnight, and the condition of the heart and respiration was such as to make the outlook appear hopeless.

The convulsions looked very much like a lesion of the cerebral cortex in the precental convolution of the right hemisphere; it might be either a widespread lepto-meningitis or a cerebral abscess. Potassium bromide was administered per rectum, and it was decided to remove the patient to the hospital for operation early in the morning if at that time it seemed feasible. The convulsions ceased about midnight, she regained complete consciousness, and when I saw her at 8 A. M. was complaining of an agonizing headache and begging piteously for relief. The mastoid region was then very tender. At operation the antrum was found to be filled with granulation tissue, the neighboring structure was soft and careous, and after cleansing the antrum a drop of pus was observed oozing in through its roof from the cranial cavity. With gouge and Rongeur the tegmen tympani antri was removed and about half a dram of pus was evacuated from an extradural abscess. This exposed an area of dura about two cm. in diameter, the circumference of which was everywhere adherent to the bone. The sigmoid portion of the lateral sinus was exposed, but proved to be in a

healthy condition. The wound was dressed with iodoform gauze, and the patient made a rapid and uninterrupted recovery.

Exhibition of Case of Mycosis Fungoides—Mycosis fungoides was first described by Alibeot in 1814. At first he thought the symptoms were those of yaws, but in 1832 he concluded it was a new disease, and called it mycosis fungoides because of its resemblance to a mushroom growth.

The course of the disease naturally divides into two stages. (a) A premycosic stage, in which the chief characteristic is the appearance of various skin eruptions resembling erythema multiforme, eczema, psoriasis, etc., but differing in that they are more capricious and more resistant to treatment than the usual type of inflammatory dermatoses. As the disease progresses these premycosic eruptions become more infiltrated and scaly and itch intensely. Either on these infiltrated areas or developing from normal skin, the tumors, characteristic of this disease arise. At first they are small and pedunculated or broad at the base, and the skin over them is smooth, but as they grow the skin becomes scaly and crusted. The tumors may be single, grouped or lobulated, and may vary in size from a pea to an orange, and may be numbered by the hundreds. This stage may last for 20 years, and at any time any of the eruptions may disappear, only to reappear within a short time without a definite cause.

(*b*) The mycosic stage begins with ulcerations of the tumors, and from the base and sides of these ulcerations the hypertrophic, fungating granulations, which give to the disease its name, appear. The course of the disease is now very rapid, and the patient dies from asthenia or some intercurrent affection.

Nothing definite is known as to the cause of the trouble. It is more frequent in males, 3 : 2.

The age limits are 15 and 73, but most cases occur between 30 and 50. It is not contagious, and no two cases have been reported in the same family. While it is probably of bacterial origin, the invading organism has not been found, the few organisms which have been described being regarded as secondary inbodies. Injections into animals have given no results.

The prognosis is bad. There have been only two reported cures in over 300 cases.

The trouble began, in this case, 16 months ago as follicular papules on the forehead and cheeks. They spread slowly at first, coalesced, and became eczematous-looking. Similar eruptions appeared on neck, back and extremeties. On chest and back are other plaques resembling enythema multiforme, except that they are persistent and scaly. Numerous tumors can be seen, some arising from previous lesions, others from normal skin. All the extremities show an elephantiasic condition, due to inflammation of the lymphatics. Only a few tumors are ulcerating.

A blood count by Dr. Hogen shows: Polymorphonuclears, 50 per cent.; eosinophiles, 8.8 per cent.; large mononuclears, 44 per cent.; small mononuclears, 32 per cent.; transitionals, 3 per cent.; mostzells, .6 per cent.

MEETING HELD MAY 27, 1907—DR. BARKER IN THE CHAIR.

Exhibition of Cases—Drs. Thomas and Cushing. Dr. Thomas. History of the patient: This man, Cheetham, has been shown before the Society

twice this year, but a brief history is given to refreshen our memories. He first came to the Hospital in October, 1905, being referred from one of the eye hospitals in Baltimore on account of double-optic atrophy following paralysis. His family and personal history are unimportant. In 1895 he began to have curious attacks, which would begin with a queer feeling about the left knee, and at times would pass up the side, and occasionally these would be followed by a jerking of the calf muscles. At first these attacks came about once a month, but later became more frequent. There was a remarkable similarity of the attacks. He kept up his work farming and teaching school. In 1898 some weakness developed in his left leg. The attacks persisted and were almost always of the same character, at times being more intense and spreading all over the body and accompanied by unconsciousness. He had in all about five such attacks before his first operation.

In 1903 he suddenly became blind, and associated with this he had a pain in his head. The blindness was transient, but his eyesight rapidly failed, and in two or three weeks it became almost as poor as at present. During this period in 1903 his left arm became weak. He recovered from this in about four weeks. From 1903 to 1905 his condition remained about the same. He came to the Dispensary in October, 1905, complaining of his eyes and nervousness. His fields were constricted irregularly, there was double-optic atrophy, he had a hemiplegic walk with weakness of the flexors, the reflexes on the left side were increased, there was an ankle clonus and a positive Babinsky. His hands were strong and no impairment of sensation could be found. Early in 1906 he had several severe attacks, and in April an exceptionally severe one, with loss of consciousness. He was followed all during the summer and records taken of his attacks. In the fall of 1906 he was admitted to the Hospital. The first belief was that there was some quiescent lesion on the right side, probably in the post-central covolution. Before the operation no sensory disturbance could be demonstrated in the left leg. The stereognostic sense and the temperature and muscle sense were good. He could read letters cut out of wood with his left foot, and could appreciate the slightest movement of the foot or toes.

Dr. Cushing—It seems appropriate to have Cheetham here again before you, since we have been able to follow him so well through so much of trouble.

The first operation was on the 22d of November, 1906, and we thought to find a quiescent growth in an inaccesible region, for the area representing the leg in the motor cortex lies under the longitudinal sinus, which spreads out a good deal laterally.

He takes ether very badly, so that at the first operation we could only turn down the bone-flap. The opening was nearly in the midline. The bone-flap was replaced, but had to be opened again the next day on account of extradural hemorrhage. It was an emergency operation, and he promptly regained consciousness. Five or six days later the flap was again elevated, and again he took the ether badly. The motor area was exposed through a small dural flap and the centers were stimulated. The cortex looked normal.

After this operation he had a period of temporary betterment and for a time was more cheerful.

Early in March he began to have very serious attacks, accompanied by unconsciousness. They were the worst attacks he had ever had.

It was a curious thing that in all of the attacks the motor symptoms of twitching began in the same place, while the sensory aura began in so many different places.

Through the continued requests of Cheetham, and really against my better judgment, I agreed to go in again. On account of his taking his ether badly, all that was possible was to open the old flap, which is always a difficult thing to do. On account of hemorrhage encountered the flap was closed with packing and the patient sent back to the ward. Five days later, without any anesthesia, the wound was opened for the purpose of removing the gauze, and, having gotten so far without hemorrhage, it was then decided to open the dura once again. Certainly this would be a case where one would expect to find numerous adhesions, but, much to my surprise, there was only one fine one found.

The dura was perfectly insensitive except when pulled upon, which caused a pain similar to that experienced in headache. It seems very much like the parietal peritoneum. The pain then found in experimental work seems to be due to pressing and pulling rather than to cutting. This time a large opening was made in the dura in the region of the posterior central convolution, and, much to my surprise, I found a cystic tumor, which ruptured as I was about to remove it, and disclosed below it another and similar tumor, which was attached to the other one, forming an hour-glass shape. There was no pain and no bleeding, so time was taken to obtain both drawings and photographs of the tumors in situ. He has had no trouble since operation, except for the first few days he had nervous attacks with sensations of weakness. A clonus could be obtained in the fingers and wrists.

Before this last operation his old hemiplegia had returned and he was almost completely hemiplegic. His hand and arm are now surprisingly well, but he still drags his toe, however.

There was a little period of increase in the acute symptoms in his eyes after the extradural clot, but recently no thorough examination has been made of the eyegrounds.

The tumor was probably at one time a glioma. Through its degeneration the cystic condition was assumed. Sir Victor Horsley has reported a couple of cases of this character.

The point to which I wish to call particular attention is the ease with which a second-stage operation was performed in this instance without a general anesthetic, and suggest that it may become of no little practical value after a more extensive trial.

Dr. Welch, merely on seeing the tumor, not having heard the history, suggested that it was a cystic degeneration of an old glioma.

Dr. MacCallum, however, was inclined to the opinion that it was a cyst formed from a hemorrhage.

It may be that it was formed by a hemorrhage into a tumor.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN. M.D. J. A. CHATARD. M.D. JOHN RUHRAH. M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan. 847 North Eutaw Street. Baltimore.

NOTICE.

THE semi-annual meeting of the Medical and Chirurgical Faculty of Maryland will be held according to previous notices during our trip to Jamestown.

The boat, (Str. Charlotte) leaves Pier 19, Chesapeake Steamship Co.'s Line, on Wednesday, September 11th, at 8 P. M. *sharp*. The first scientific session will be called to order about 9 P. M. that evening. We arrive at Norfolk next morning (Thursday) and will be welcomed by a Committee from Norfolk Medical Society. Members will then be conveyed to the Exposition grounds by special boat; that day all the members will have special invitations to the Maryland Day exercises, in Maryland Building. The early evening may be spent at the grounds and late dinner will be served on the boat.

Friday will be devoted to sight seeing, the boat leaving at night when the second scientific session will be held "en route" home.

Arriving in Baltimore early Saturday morning, breakfast will be served on the boat.

HOUSE OF DELEGATES.

The meeting of the House of Delegates will be held on Wednesday afternoon, (the day of sailing) at 4 P. M. in the Faculty Hall, No. 847 N. Eutaw St., so that delegates, who have been unable to go to Jamestown, may attend this session.

Scientific Session.

Wednesday, Sept. 11th, 9 P. M.

President's address, Dr. Chas. O'Donovan.

"The Philosophy of Disease," Dr. Wm. H. Pearce.

"The Effort to Prosecute Unregistered Practitioners of Baltimore City," Dr. Herbert Harlan.

"Acute Pyelitis due to Acute Appendicitis," Dr. Guy H. Hunner.

Friday, Sept. 14th, 9 P. M.

"The Operative Treatment of Cancer of the Stomach, with report of Cases," Dr. Jos. H. Branham.

"Psychatherapy in the Treatment of Functional Neuroses," Dr. Arthur P. Herring.

"Should Prisoners Deficient either Mentally or Physically be tried in our Courts of Justice," Dr. Theodore Cook, Jr.

PROPHYLAXIS OF SOCIAL DISEASES.

By Prince A. Morrow, A.M., M.D.

READ BY INVITATION BEFORE THE STATE MEDICAL SOCIETY OF MARYLAND, THE STATE CONFERENCE OF CHARITIES AND STATE FEDERATION OF WOMEN'S CLUBS.

I WISH to express my appreciation of the honor of being invited to appear before this representative body of the medical profession, members of the State Conference of Charities, and of the State Federation of Women's Clubs. It is a source of especial gratification to find so many men and women engaged in different spheres of social activity, uniting with medical men in the discussion of a problem of preventive medicine which has such important relations with the interests of the social welfare. This composite gathering exemplifies the solidarity—the community of interest and responsibility existing between the medical profession and social workers in all questions relating to the physical and moral health of the community. The office of hygiene is not limited to the care of the health of individuals; its broader function is to develop all those conditions which conduce to public health and which in its highest expression is inseparable from public morality.

It is generally conceded that medicine constitutes the most important department of human knowledge, and its value to humanity is largely measured by the degree in which it is applied to the prevention of disease.

Those of you whose charitable activities are directed to the relief of the dependent members of society, cannot fail to recognize that disease is one of the most important factors in the causation of the destitution which requires relief. The prevention of disease, which transforms the bread winner into the dependent upon charity, has a most important economic as well as humanitarian value.

The medical profession has long recognized that the fight against communicable diseases is not simply a struggle against microbes, but a warfare, as well, against bad social conditions, and, further, that the conquest of these diseases is not possible without the aid and co-operation of social agencies which can effectively intervene in the correction of the bad social conditions through which disease germs are spread. The value of the combination of medical and social agencies has been most signally shown in the warfare which is now being waged against the Great White Plague; its success has been rendered possible only by the education of the public and the effective aid of social workers and public-spirited citizens in the improvement of the housing and living conditions of the people.

With tuberculosis, perhaps more than tuberculosis, social diseases constitute the greatest social scourge of our modern civilization. This class of diseases has been aptly designated "The Great Black Plague." Working in darkness and disguise, protected by their privacy, their shame and their secrecy, they infect, unseen, the social body. Without the pale of public interest or sympathy, unfettered by any semblance of sanitary control, they have been practi-

cally abandoned to their own evolution. Their neglect has always been considered the reproach and their prevention the despair of sanitary science.

It is a sign of progress and a hopeful augury of success that men and women representing influential social organizations have signified by their presence here today their willingness to join forces with the medical profession in a socio-sanitary movement which, it is hoped, will limit at least the diseases we wish to prevent.

It is eminently fitting that women should interest themselves in this movement for the prophylaxis of social diseases. It is upon women that the burden of shame and suffering, of disease and death, is chiefly laid—not so much, perhaps, upon that unfortunate class who are regarded as the chief agents in the propagation of these diseases, but upon pure women, who do not always find, even in the sanctuary of marriage, a safeguard against "the diseases of the women of the streets." By a strange irony of fate, the diseases of vice transplanted to the bed of virtue often become intensified in virulence and danger; their worst effects are developed in fulfilling the functions for which marriage is instituted. It is not alone upon the virtuous wife, but upon the children who are a part of her being that the blighting, destructive force of this social scourge most heavily falls.

Before an exclusively medical audience it would scarcely be necessary to refer to the pathological significance of the class of infections comprehended under the general term "social diseases," but before a mixed audience brief reference may be made to their extensive prevalence and their dangers to the individual and society in order to emphasize the importance of the prophylactic work which it is hoped may be inaugurated in this city.

As these diseases are not subject to official registration, there are no available statistics which enable us to formulate the amount of venereal morbidity in this country. Competent European observers state that 75 per cent. of the adult male population have or have had gonorrhea, and 10 to 18 per cent. contract syphilis. It would be a conservative estimate to state that the morbidity from both these infections would represent 60 per cent. of the adult male population in this country. While these diseases may occur at any period of life, they are essentially maladies of early life, probably 60 per cent. of infections occurring before the twenty-fifth year.

The danger of these diseases is measured not only by their effects upon the health or life of the individual, but upon the family and the race. Our conception of their pathological import has been singularly amplified by the acquisitions made to our knowledge within the last third of a century, especially of the serious nature of gonococcus infection in women. Gonorrhea, in addition to its local inflammatory complications, is often the cause of permanent sterility in the male. It has a much wider range of morbid action than was formerly supposed; the gonococci are susceptible of being taken up in the circulation, producing serious and deforming

inflammation of the joints and lesions of internal organs which may terminate fatally.

The significance of syphilis as a danger to health and life is not measured so much by its immediate effects as by the changes it sets up in certain internal organs essential to life; such as the brain, liver, heart and arterial system, and which are the cause of death at a more or less remote period. Many of these serious manifestations occur after the tenth year of the disease, and are especially liable to involve the nervous system. It is estimated that 90 per cent. of cases of locomotor ataxia, a large but indeterminate proportion of the paralyses and general paresis are caused by syphilis.

Recent investigations in the French insane hospitals show that 25 to 39 per cent. of deaths in those institutions may be traced to syphilis.

The chief significance of these diseases as a social danger comes from their introduction into married life. It is the popular impression that they are spread exclusively through illegitimate sexual relations. Unfortunately, a large proportion of men contract these diseases at or before the marriageable age. Many of them marry, ignorant of the fact that they are bearers of contagion to their wives and offspring.

Gynecologists tell us that 80 per cent. of the inflammatory diseases peculiar to women and 50 per cent. of all the operations performed by surgeons on the maternal organs are the result of gonococcus infection.

One specific effect of this disease upon the pelvic organs of women is to extinguish the conceptional capacity. It is estimated that 50 per cent. of gonorrheally infected women are rendered permanently sterile.

While gonorrhea is not susceptible of hereditary transmission, it is liable to infect the eyes of the child at birth. Eighty per cent. of the ophthalmia of the new born, and 15 to 20 per cent. of all blindness is attributed to gonococcus infection, to say nothing of the vulvo-vaginitis, the arthritis and other accidental infections of children in family life.

If the wife is infected with syphilis, in addition to the risks to her individual health already referred to, the disease may be transmitted in full virulence to the offspring, killing them outright or resulting in physical and mental weaklings. From 60 to 80 per cent. of syphilitic children die before being born or shortly after birth: those that finally survive are subject to various organic defects and degenerative changes, which are susceptible of being transmitted to the third generation.

It will thus be seen that diseases of this class, from their specific effect upon the reproductive organs, their damage to the procreative capacity, their deteriorating influence upon the offspring, constitute the most powerful foes to the productivity, the vitality and physical progress of the race.

It was the recognition of the significance of these diseases as a social peril that was the impelling motive to the inauguration of

the work undertaken by the American Society of Sanitary and Moral Prophylaxis. It was believed by those who started this movement that it was time to break with the existing policy of silence and inaction, and to organize a social defence against a class of diseases which are most injurious to the highest interests of society.

The basis of any intelligent scheme of prophylaxis is the adaptation of its measures to the causes of the disease and the conditions under which it is spread. While sanitary science has been reproached for its utter inefficiency in evolving any practical scheme of control, it is evident that the prevention of social diseases cannot be treated as a purely sanitary problem. Their causes reside in conditions which lie entirely without the sphere of sanitary control, and their communicative mode cannot be reached by repressive measures. It was determined to enlist the co-operation, as far as possible, of all the social forces which could render effective aid in the corrections of the conditions of which these diseases are the outgrowth.

From whatever standpoint this field was surveyed, the indifference of the public, the reckless and voluntary exposures to infection, the martial contaminations, the hereditary horrors, the most obvious causes seemed to converge and center in the focal point of ignorance.

The public is indifferent because ignorant of the extent and significance of venereal morbidity; the young who voluntarily expose themselves do not know the veritable danger of these infections, nor the imminence of this danger; the men who carry disease and death into their families are ignorant of the laws of venereal contagion, its varied and multiple modes; they do not know its terrible consequences to their wives and children.

While there are other and contributory causes, the basic cause is ignorance. The keynote of this movement, then, was sounded as a campaign of education, a crusade against ignorance. This ignorance on the part of the public is not surprising in view of the fact that both social sentiment and professional ethics have always united to cover up and conceal these diseases; all the educational agencies of our social life are organized upon a basis of silence as to their existence even. On the part of the young, ignorant of the dangers which come from the irregular exercise of the sex function is compulsory; sound sex instruction is forbidden as improper; parents, teachers and scholastic instructors are banded together, a complicity of silence.

The public cannot be expected to seek deliverance from a hidden danger, the gravity of which it is utterly incapable of measuring, and the reality of which it scarcely suspects.

The first indication is to turn on the purifying light of publicity, to give to the public a knowledge of the facts which so vitally concern its interests, the extent and dangers of the diseases to the individual and to society, and their modes of contagion, direct and indirect. It is necessary to educate the conscience as well as the

intellect of the people in order to create a public sentiment in favor of this work which will lead to an intelligent and active co-operation. It is only by opening up the humanitarian aspects of the situation, by exposing the dangers to the innocent members of society, that the conscience of the public can be touched and aroused to the significance of these social crimes and the moral obligation to aid in their prevention. There is needed not only a change in the apathetic attitude of the public, but a change of traditional ideas, of the mental attitude of the public toward the sex problem—a reversal of the policy of our educational system which now forbids instruction in the laws of life and sex.

The ideal of a good education to which most parents cling is one which entirely ignores the existence of sex, that most important fact of life. All thinking men must recognize that the development of the sex function is intimately associated with the physical, mental and moral growth of the individual. Sex is the physical basis of love, of the family sentiment, even of the existence and prosperity of society. The object of education is to fit the individual for complete living, which includes not only self-preservation, but self-perpetuation. From earliest infancy instruction is given about the functions of the body essential to its maintenance, the care of the stomach and bowels, what to eat and drink and what to avoid, but no word of advice as to the care or warning as to the abuse or irregular exercise of that function which, from a biologic point of view, is the most important function of the human body.

One lesson, indeed, the majority of parents give, viz., that the system of generation is a system of shame. This impression is so grounded and fixed in the mind of youth that it is apt to dominate his mental attitude throughout life. This sex instruction of their sons, so inauspiciously begun, is then committed to haphazard sources, to servants, to older and dissolute companions, to quackish literature, to be completed, too often, by harlots.

Our educational program proposes to fill this glaring hiatus in home and scholastic instruction, to take account of the sexual organization of the individual, the origin of facts of life and sex which are now regarded as forbidden subjects.

As I have elsewhere said, the function of the medical profession is to insist upon the value of this education and supply the requisite knowledge, intrusting its practical application to those who command the facilities and are better qualified by experience and a knowledge of specific methods. This education should be begun early, before sensuality is awakened and the curiosity of youth in regard to the mysteries of life and sex takes on a dangerous turn. Upon this foundation should be built, later, instruction in the physiology and hygiene of sex, which should include the true purpose of the sex function, its essential dignity, and, further, that its impulses should be educated, controlled and directed in a proper channel. Later he should be taught the dangers, both physical and moral, which come from the irregular exercise of the sex function. The high purpose of this education is to teach young men how to

live according to the laws of a healthy nature by letting them know what those laws are. It aims to promote clean living by cultivating a right attitude of mind toward the passions and appetites; its essential object is to promote continence as the surest prophylactic against venereal infection.

This innovation proposes to substitute sound, sanative and wholesome knowledge of the sex function for the erroneous and demoralizing instruction the youth now receives from ignorant and often vicious sources.

Sound knowledge never does harm; it is knowing things wrong that does the mischief. A celebrated Grecian philosopher has said "the most needful piece of learning for the uses of life is to unlearn all that is untrue." This applies with especial force to the existing knowledge of young men of the present generation in sex matters.

It is important that the young man who has had no sex instruction except what he has picked up from ignorant or vicious sources should unlearn the untruth "that the sex function is given solely for sensual pleasure;" he should unlearn that "the exercise of this function is essential to his health and that he has a natural right to indulge his sexual impulse as he pleases;" he should unlearn all those physiologic fallacies upon which the sexual necessity and the conventional standard of morality are based, and especially should he unlearn the ethical heresy that one-half of humanity has imperious duties which the other half may repudiate or disclaim.

While proper sex instruction may trench upon the domain of morals, it is not suggested that the physician should usurp the function of the religious or ethical teacher. It is the province of the physician to teach the hygiene of all the functions of the body; it is his duty to warn against the exercise of any function under conditions which cause disease. The irregular exercise of the sex function, whether it is termed "incontinence" or "immorality," is the direct cause of that vast mass of misery and disease we are now considering. If continence in young men is healthful and compatible with the highest physical and mental vigor, if incontinence is the frequent cause of their physical and moral wreckage, it is the duty of the physician to warn against promiscuous cohabitation. "Physicians," declares Dr. Osler, "should be the apostles of continence." The teaching of continence does not imply, as has been asserted, a Pharisaical assumption of superior virtue; it is an impersonal interpretation of the physiologic laws of man's nature as developed by science and confirmed by experience. In the matter of sex relationship the teachings of hygiene and morality are in complete accord.

In thus emphasizing the value of instruction in the physiology and hygiene of sex as a chart for the regulation of sexual conduct, we do not undervalue the teaching which properly comes within the province of the clergy. Hygienic teaching should be reinforced by an appeal to the conscience, so that the duty of clean living may be impressed with the force of a moral obligation.

We may now inquire what measure of preventive value we may

reasonably expect from this education. No one indulges for a moment the illusion that it will prove an infallible corrective of incontinence. It is believed, however, that many young men when fully instructed as to the peril to the body, the mind and the character which comes from licentious living will choose the safer path of continence until they marry. The chief value of general enlightenment will be the safeguarding of marriage from venereal infection. It is inconceivable that the havoc wrought by these diseases in the home and family will continue when men realize the fearful consequences of marrying with an uncured venereal disease. An enlightened public opinion, which is the strongest force in the evolution of the conscience of the race, will no longer tolerate these social crimes.

I have thus dwelt, and I fear at a wearisome length, upon this, the most important feature of our program, because I believe that the chief hope of success in the work before us lies in the hygienic and moral education of the rising generation. Before dismissing this part of the subject, allusion may be made to that cynicism which, masquerading under the guise of common sense, declares that the impelling motive to licentious relations between men and women cannot be restrained by any considerations of health or morality, of consequences to themselves or others. This despair of educational and moral influences would paralyze all the efforts now being made in every department of social life to correct its abuses, to raise its ideals and to promote its welfare.

The prophylactic value of treatment is so evident to medical men that only the briefest mention of this part of the program will be made. Its chief object is to prevent those already infected from infecting others by promptly sterilizing sources of contagion. To accomplish this object the provisions made for the treatment of these diseases should be enlarged, and made available to all, not so much in the interest of the patient himself as in the interest of others he might expose to infection.

As the question of the social evil is to form the subject of another paper on the program, I will touch but briefly upon what generally is regarded as the crux of the entire situation. Certainly there can be no intelligent or comprehensive system of prophylaxis framed which ignores the relation of cause and effect between the social evil and social diseases. It is well, however, to clear away a misconception which exists in the minds of many as to the measure of responsibility of public women for the spread of the diseases of vice. In the ordinary conception, the prostitute, with her cortège of infections, is the exclusive cause of their propagation; but, while the prostitute is the chief source, she is by no means the exclusive agency in its spread; she is but the purveyor of the infection; she returns to one or several consumers the infection she has received from another consumer. It is not the prostitute, but her partner, who carries the poison home and distributes it to his family. It is the husband and father who is the responsible

cause of the wreckage of the health and lives of innocent women and children.

Now, the responsibility of the male factor in the spread of these diseases has always been minimized. This constitutes the radical defect of reglementation from a sanitary standpoint. No more inefficient or incomplete sanitary measure could be devised than the examination of public women with the view of eliminating sources of contagion while the male factor in the spread of disease is entirely ignored. If the woman's body is found diseased it is withdrawn from circulation until it can be certified as safe for the consumer, while the latter is permitted to contaminate other women without the shadow of control, even to carry the contagion into his own family. Sex may qualify morality, but it does not qualify the laws of contagious disease. The sanitary feature of this system is condemned by its practical results, without reference to objections on moral grounds.

This same unilaterality is manifest in the condemnation of woman as the chief offender against morality. All the so-called "moral crusades" are directed against women alone. In the descent upon disorderly houses the unfortunate women are fined and imprisoned, while the men who are there for the same immoral purpose are allowed to go scot free. I have long ago stated my conviction that the reversal of this one-sided policy—treating men and women precisely alike—would break up these houses.

In tracing the essential cause of prostitution we find that, while socio-economic conditions are contributory causes, we must face the fact that the taproot of this evil is grounded in the polygamous proclivities and practices of man. More than the inherited tendencies to vice in certain women, more than the love of finery and luxury, the laziness, the economic dependence, the force of want that impels many of them along the road to ruin, more than all these and other alleged conditions, the chief cause is the unbridled instinct of man, which, in seeking the means of its gratification, creates the supply to satisfy the demand. The prostitute is largely the creature of man's sensual appetite. The methods of dealing with the social evil have been based upon a recognition of this demand as a necessity for men, and they fail because they endeavor to correct the effects without touching the cause.

As the work of the society has thus far been directed chiefly along educational lines, it can hardly be said to have a definite policy in dealing with the social evil, except that it rejects all measures which ignore the moral issues involved. My own personal view is that this problem should be approached through educational and moral influences rather than by legislative intervention. Efforts should be directed not to making prostitution safe, but to prevent the making of prostitutes.

The first indication is to lessen the demand by influences and

agencies which act upon the intelligence and moral sense of the individual, by education in the law of sex which teaches that the sexual instinct should be educated, restrained by reason and directed into a monogamous channel, by exposing the danger to the physical health and moral character which are inseparable from licentious relations—dangers which may destroy his reproductive powers or blight the health of his children. This instruction would be incomplete without impressing upon young men that the use of alcohol is one of the most powerful of all influences inciting the sexual debauch.

The second indication is to curtail the sources of supply by throwing additional safeguards around young women of the working classes and the large population of homeless and friendless girls, from which the ranks of prostitution are chiefly recruited. This may be done through education and the aid of those social agencies which have been organized for the protection of young women.

A vigorous and unrelenting fight should be made against the purveyors of prostitution—the white-slave trade, the cadet system, the employment agencies, personals in the newspapers—against proxentism in all its forms. Quack advertisements should be suppressed as one of the most powerful agencies in the spread of venereal infection. They minimize its dangers, and, by giving deceptive assurance of cure, the victim goes on spreading the germs of danger in ignorance that he is the bearer of contagion.

In conclusion, brief reference may be made to the experimental work done by the Society of Sanitary and Moral Prophylaxis since its organization in New York over two years ago. It was recognized that this was a new and untried field, and it was necessary, first of all, to study the situation. Since the evil we wish to correct is largely the result of ignorance, the first indication seemed to be the enlightenment of the public as to the magnitude and significance of the evil. The work of publicity has been especially difficult because of the uncompromisingly adverse attitude of the newspaper press, which excludes all mention of this class of diseases. Through one channel or another, however, this knowledge is generally getting into circulation.

The next indication appeared to be the education of the rising generation in sex matters. Sex instruction, which contemplated an innovation upon the established educational system, was recognized to be not only delicate, but exceedingly difficult, as it ran counter to deeply-rooted prejudice, as well as traditional custom. Much study has been given to the character and scope of this education, the age at which it must be given and the agencies through which it should be imparted. The education of the young men and women of the working classes, and the men of the army and navy service, has also been the subject of careful study. The subject of throwing

additional safeguards around marriage, ethical as well as legal, has been considered. The results of these studies appear in the transactions of the society, recently issued.

Since the ordinary channels of communication with the public are closed, the educational work of the society has been attempted through pamphlets, tracts, leaflets and through conferences and lectures in schools, colleges, settlements and in various social organizations. The instructors in the physical training department of the Y. M. C. A. have shown a most cordial willingness to co-operate in this educative work. Many teachers, instructors and pedagogists in various institutions throughout the country have exhibited, by letters of inquiry and commendation, a deep interest in this movement. Charity organizations, humane societies and women's clubs are becoming interested. While physicians generally have not responded to the demands of this work with that spontaneity and enthusiasm which was hoped for, yet the best element in the medical profession and a large and influential lay element have become members of the societies organized in various cities.

The progress of this movement cannot fairly be measured by the results of actual accomplishment. Seed has been sown which, it is believed, will germinate and bear fruit later on. "Education Within the Medical Profession," which formed the subject of one of the first papers read before the society, is actively going on through papers and discussions in medical societies, clubs and associations, and many physicians who had not kept pace with the recent advances made in our knowledge of the social dangers of these diseases are now becoming impressed with the importance of this work.

One result of this movement which serves to show the breach made in the walls of traditional prejudice is illustrated by this gathering here. Thanks to the change in professional and social sentiment, we have now the courage to bring out in the open this forbidden topic which the medical profession has always discussed behind closed doors, to show this social scourge to the public face to face, to even pronounce its name without fear of shocking the sensibilities of a public audience.

Finally, the work in which your co-operation is solicited is difficult, and, there is no disguising the fact, is unsavory, even distasteful. It will never receive the endorsement of fashion or society, nor gain the plaudits of the multitude; popularity will never perch upon its banners; it can be undertaken only from a sense of duty. This duty imposes upon the medical profession a responsibility which cannot be evaded, and upon all those interested in the social welfare a moral obligation which cannot be disregarded. It is a work not only in the interests of preventive medicine, but for the good of humanity, and, in the words of the illustrious Pasteur, "when there is question of good to be done, our duty ceases only with our ability to do more or do better."

REPORT OF MEMOIR COMMITTEE.

Robert Lewis Annan M.D.

was born in Emmittsburg Md., February 22, 1831. He obtained his literary education at Washington and Jefferson College, from which institution he graduated in 1852. His medical education was obtained at the University of the City of New York and he received his degree from there in 1855. He settled in Emmittsburg soon after his graduation and at once began the practice of his profession. He was twice married, his second wife, who was Miss Hessie Birnie, with eight children, still survives him. He was a devoted and conscientious practitioner and was a ruling elder in the Presbyterian church for a number of years.

He died of paralysis of the heart at Emmittsburg on January 14, 1907, aged 76 years.

The Medical and Chirurgical Faculty of Maryland having learned of the death of Dr. Robert Lewis Annan have adopted the following:

Resolved 1st.—That this Faculty is deeply grieved at the loss they have sustained in the death of Dr. Annan.

Resolved 2d.—That the loss of our members who reside in the counties is most keenly felt in that they can do so much to hold up the high ideals of medicine in the communities in which they practice.

Resolved 3rd.—That we extend to the family of Dr. Annan our heartfelt sympathies in the great loss they, as well as we, have sustained.

Resolved 4th.—That a copy of these Resolutions be sent to the family of Dr. Annan and a copy placed upon our records.

Isaac Edmondson Atkinson M.D.

the son of Mr. James E. Atkinson, was born in Baltimore Md. on the 23d. day of January 1846. His literary education was obtained at the "School of Letters" of the University of Maryland and his medical education from the medical department of the same institution from which he received his degree of M.D. in 1865. He married Miss Virginia R. Duvall and leaves three daughters and one son. He was descended from an old quaker family. He was a member of the Maryland and University Clubs, of the Elkridge and Baltimore Country Clubs and of the Bachelor's Cotillion Club. In 1873 he was made one of the City Vaccine physicians and in 1883 was made superintendent of vaccination. He was the attending physician of the Baltimore General and Special Dispensary. He held the following important chairs in the Medical Department of the University of Maryland: Clinical Professor of Dermatology, 1879-1881; Professor of Pathology, 1881-1886; Professor of Materia Medica, 1886-1890; Dean of the Faculty, 1890-1893; and Emeritus Professor of Therapeutics and Clinical Medicine at the time of his death. He was President of the Clinical Society of Maryland; he was elected a member of the Medical and Chirurgical Faculty of Maryland in 1874, its Vice-President in 1881 and again in 1884, and its President in 1887; he was made President of the American Dermatological Society in 1887; he was Consulting Physician to the Johns Hopkins Hospital and a member of the Lunacy Commission of Maryland.

He made many valuable contributions to the medical Journals and was the author of an article in Pepper's System of Medicine.

The Medical and Chirurgical Faculty of Maryland, having learned of the death of its fellow-member and former Vice-President and President, Isaac Edmondson Atkinson M.D., adopted the following MINUTE and directed that a copy be sent to the family of Dr. Atkinson and a copy preserved among our records:

It is with deep regret and profound sorrow that this Faculty has learned of the death of Isaac Edmondson Atkinson M.D. He was for many years an honored, highly respected and influential member of this body and the highest offices within its gift were conferred upon him. His opinion on any matter that came up for discussion was eagerly sought and, as his judgment was sound, it carried great weight. He was always deeply interested and concerned as to the welfare and good name of this Faculty and was active in devising ways and means for its advancement along ethical and professional lines. He was a very genial man, thoroughly honest and reliable, with a clear insight into the many complex problems in medicine he was called upon to solve, he was kind and considerate of the feelings of his medical associates as he was of all with whom he came in contact, he was modest to an unusual degree. These traits in themselves were sufficient to endear him to his medical brethren, not only in this Faculty but everywhere, and all looked upon him as a friend and companion, and his society and advice were eagerly sought for. The medical profession held him in the highest esteem; the Medical Department of the University of Maryland gave him the most valuable gifts in its possession, the Clinical Society made him its president, and the profession outside of the city showed their appreciation of him by making him the President of the American Dermatological Society. When small-pox began to get a foot hold in this city in 1883 he was called upon by the authorities to superintend the measures to be taken to stop its spread. He was a man of a very lovable disposition, kind and considerate of the feelings of others, he was intensely human and seemed to know how to make allowances for and guide those in trouble or distress. He was careful and accurate in his methods and as diagnostician he had few equals. He did the best possible for his patients at all times and in such a quiet, unostentatious manner that even those afflicted with serious maladies were not permitted to become depressed but were buoyed up by his unfailing cheerfulness. He was a man of deep convictions and fearless in doing what he knew to be right. He gave no undue prominence to any department of medicine nor surgery and thus became one of the city's most eminent "Family Physicians". He attracted by his many charms of grace and manner hosts of friends and once you were his friend you always were.

This Faculty, the medical profession, the City and State have met with a great and serious loss in the death of Professor Atkinson.

Charles Carrott Bombaugh A.B., A.M., M.D.

was born in Harrisburg Pa., February 10, 1828. His great-grandfather served in the Continental Army during the Revolutionary War, was chief

burgess of Harrisburg in 1794 and entertained President Washington when on his way to quell the "Whiskey Insurrection." He was fitted for college at the Military Academy of Capt. Partridge, was graduated from Harvard University in 1850 and from that institution received the degree of A.B. in 1850 and of A.M. in 1855; he graduated from the Jefferson Medical College of Philadelphia with the degree of M.D. in 1853. At the outbreak of the Civil War he was engaged in private practice but was induced to give it up and enter the army; he was commissioned surgeon of the Second Regiment; he served as medical officer in General Stone's division on the Potomac and then in General Sedgwick's in the Peninsular campaign; he was with McClellan during his retreat to the James River and nearly lost his life from exposure at that time. In September 1862 he was sent to Philadelphia for hospital duty and later to Baltimore, where he remained until the close of the War. He was eventually obliged to abandon the practice of medicine on account of his impaired health and subsequently devoted himself to journalism and general literary pursuits. Many of the insurance companies recognizing his abilities secured his services as their medical examiner. In 1864-1865 he was editor of the Baltimore American. In 1865 he established and for 33 years successfully conducted the Baltimore Underwriter, this he did in so able a manner that it maintained a leading position among that class of papers. He was a frequent contributor to medical and other journals and was called upon to make addresses at medical, military and underwriter gatherings. At the centennial celebration of the founding of the City of Harrisburg and the county of Dauphin in 1885 he was chosen as the poet. He was a great reader and was fond of delving among the rare and curious things in literature; he wrote several books as the result of these labors, the most famous being "Gleanings for the Curious", toward the close of his life he added another, entitled "Facts and Fancies for the Curious". His most important work was probably the "Stratagems and Conspiracies to Defraud Insurance Companies", an authentic account of all the remarkable cases; he was also the author of "The Book of Blunders", "First Things" and "Literature of Kissing". He joined this Faculty in 1897; he was a member of the American Medical Association, of the Harvard Club, of the University Club of Baltimore, of the military order of the Loyal Legion, of the Maryland Society of the Sons of the American Revolution and others. He died of gastritis at his home in Baltimore, May 24, 1906, aged 78.

Dr. Bombaugh had a very interesting, and, in some respects, unique career; as a general practitioner before the War, as a surgeon of marked ability in that War, as a student and writer and more especially as a rambler and investigator among the byways of literature, he showed a diversified character, patience, courage and devotion to duty. He was a man of generous impulses and he labored for that which was best and noblest. That he was an original thinker, his works abundantly testify. He was social by nature, fond of his friends, of whom he had a host, and he was loyal and sincere.

The Medical and Chirurgical Faculty of Maryland having learned with deep sorrow of the death of their fellow-member, Dr. Charles C. Bom-

baugh, desire to place on record their estimate of his high character and their regard for him as a physician. The following was adopted and directed to be placed upon the Minutes and a copy sent to the family of Dr. Bombaugh:

In the death of Dr. Bombaugh this Faculty has lost one of its most valued members, one who had the highest interests of this body at heart; his active interest, as a member of the American Academy of Medicine, in promoting the cause of a higher standard of preliminary education before entering upon the study of medicine, is to be highly commended. We honor him for the skill and bravery he displayed in the Civil War and rejoice that so many positions of importance were given to him. At the close of the War, instead of retiring from active labors, as he might well have done, his health having suffered, he gave up the practice of medicine only to devote himself to occupations suited to his changed condition of health; we rejoice that his labors have borne such good fruit and that he was able to add to the sum of human knowledge. He was a social man, fond of his friends and of humanity in general, kind, generous and brave, he made hosts of lasting friendships. He was honored and respected in all of the various walks in life he saw fit to follow. He has left behind him a fragrant memory.

This Faculty extends to the family of Dr. Bombaugh their sincere sympathies in the sorrow they are called upon to bear.

Thomas Wilkinson Greenley, M.D.

was born at Hillsboro, Caroline County, Md., November 6, 1865. He was educated at Swarthmore College, Pennsylvania; Pharmacist at Easton for several years; pupil of Dr. J. M. Wilkinson, Dover, Del.; M.D., University of Maryland, 1888; practiced at Trappe, Talbot County, Md., 1888-1895; later practiced in Baltimore. In October, 1891, he married Miss Nellie B. Clark, youngest daughter of the late I. Davis Clark of Trappe, Talbot County, who died about seven years ago.

He died November 16, 1906, at Saranac Lake, Adirondack Mts., N. Y., from tuberculosis, aged 41.

John H. Hessey M.D.

was born in Cecil County Md. April 6, 1853. He received his literary education at Washington College, Chestertown Md. from which he received his degree of A.B. His Medical education was obtained at the College of Physicians and Surgeons of Baltimore from which institution he received his degree of M.D. in 1878.

Howard H. Hopkins, M.D.

was born in Baltimore Md. February 2, 1848. He received his preliminary education at the Maryland Agricultural College and his medical education from the University of Maryland, from which institution he received his degree of M.D. in 1869. He resided and practised his profession in New Market, Frederick Co. Md., at which place he died May 26, 1906 in the 58th. year of his age.

JULIUS A. JOHNSON M.D.

was born at Easton Md., July 15, 1849. He received his degree of M.D. from the University of Maryland in 1871. He joined this Faculty in 1878. He was President of the Talbot County Medical Society; was physician to the county jail; and was pension examining surgeon. He died at his home near Easton Md., May 9, 1906, aged 56. He enjoyed a large practice and had the respect and confidence of the community in which he lived and labored.

The Medical and Chirurgical Faculty of Maryland having learned with profound sorrow of the death of their fellow-member, Julius A. Johnson M.D,. desire to place on record their regard for him and have adopted the following:

Resolved 1st.—That in the death of Dr. Johnson this Faculty has lost a valued fellow-member and one who had the interests of this body at heart.

Resolved 2d.—That he was an able, painstaking and conscientious physician and devoted himself unreservedly to the welfare of his patients.

Resolved 3rd.—That we highly commend him for his services as President of the Talbot County Medical Society in that by his influence and example he aided the Faculty in extending and perfecting its work in the counties.

Resolved 4th.—That we honor him for the influence he was able to exert in the community in which he lived and we rejoice that he was called upon to fill so many positions of trust and responsibility.

Resolved 5th.—That a copy of these Resolutions be sent to the family of Dr. Johnson and a record made of them upon our Minutes.

THOMAS SARGENT LATIMER M.D.

was born at Savannah, Georgia, June 17, 1839. He was educated at Sherwood Academy, York Pa. In 1861 he received his degree of M.D. from the University of Maryland. From 1862 to 1865 he was Assistant Surgeon and Surgeon in the Confederate Army; at Richmond 1865-1866; Resident Physician, Baltimore Infirmary, 1866-1868; Professor of Anatomy, Baltimore College of Dental Surgery; he held the following positions in the College of Physicians of Baltimore: Histology and Pathological Anatomy 1873, Surgery 1873-1876, Physiology and Diseases of Children 1876-1883, Practice of Medicine 1888, Physician-in-Chief of the Pasteur Department City Hospital; President of the Faculty of the College of Physicians and Surgeons of Baltimore; President of the Baltimore Medical Association, 1872-1873; Orator of this Faculty in 1873, its Vice-President 1882-1883 and its President 1884-1885; Attending Physician to the Nursery and Child's Hospital; President of the Clinical Society of Maryland 1880-1881; member of the Lunacy Commission of Maryland; Professor of the Diseases of Children in the Baltimore Polyclinic 1884; Co-Editor Baltimore Medical Journal 1870-1871; Editor Physician and Surgeon 1873; a contributor to Harris' "Principles and Practice of Dentistry" and Loomis' "Text-Book of Medicine". He joined this Faculty in 1866. He died at his home in Baltimore of an affection of his kidneys, May 16, 1906, aged 67.

Dr. Latimer's loss will be keenly felt not only by this Faculty, the College in which he was laboring at the time of his death and his family but by this community, the State and the country at large, for a reading of the many and important positions he held shows what his abilities and influence were. He was a man peculiarly fitted for his vocation and his ability to fill almost every department of medicine and surgery with credit is proof of the diversity of his gifts. He was a gentle, quiet, unostentatious worker and investigator and as such exerted great power and influence. He was careful and exact in his methods of work and his results were to be relied upon. Those who knew him best, loved him most; he commanded the honor and respect of all who were thrown in contact with him, so kind and trustworthy was he. The greatest good seemed to have been the inspiration of his life and nothing satisfied him but the best in so far as he was able to attain it. His energies were always directed towards the highest ideals, whether as President of this Faculty, as Professor in his college or in dealing with the sick poor he never failed to give of the best and noblest that he had. Many today mourn his loss and his place will be difficult to fill.

The Medical and Chirurgical Faculty of Maryland having learned with deep regret of the death of their fellow-member and Ex-President, Dr. Thomas S. Latimer, has directed that the following be recorded in their Minutes and a copy sent to his family:

In the death of Dr. Latimer this Faculty has lost a valued fellow-member and an ExPresident who, during his term of office, added much to the progress of the Faculty. He was an energetic and efficient member and he had the best interests of the Faculty at heart and strove in every way in his power to advance its welfare. He was an upright, high-toned gentleman, not only in his professional relations but in all his walks of life; he was brave and courageous and his convictions were very strong; he was a thoughtful student, careful and exact in all his work and this made him a power among his medical brethren; he was very conscientious and was governed only by what he thought was right and just. He enjoyed the confidence of the profession and the many offices he was called upon to fill as a teacher and guide showed in what esteem and regard he was held. He was kind and gentle and gave of the best that he had to his patients, with the result of securing a large practice and of attracting to himself hosts of friends. He was a skillful physician and surgeon and this secured for him many positions of trust and responsibility. This City and the State at large, for he was called upon to counsel with her, have lost a valuable citizen and one who always had at heart the best interests of the community.

The Faculty extends to the family of Dr. Latimer its sincerest sympathy in the great loss they have sustained.

ELISHA E. MULLINIX M.D.

was born in 1850; he was the oldest son of the late Leonard C. Mullinix of Frederick Co. He obtained his literary education at Frederick College and his medical education at the University of Maryland and graduated in the class of 1874. He was Resident Physician at the University Hospital and, after spending three years in Baltimore, removed to Urbana, where, during the past thirty years he has practised his profession. He built up a large and lucrative practice. He died at his home in Urbana after a week's illness from pneumonia, March 5, 1907, aged 57 years.

VAN LEAR PERRY M.D.

was born August 13, 1868, at Harper's Ferry, Va., he received his literary education at Hampden-Sidney College and his medical education at the University of Virginia and at the Jefferson Medical College of Philadelphia, from which latter institution he graduated in 1892. He married Miss Elizabeth Travers Green of West Virginia. We quote from the proceedings of the Prince George's County Medical Society at a special meeting held to take action in regard to the death of Dr. Perry as the best way of informing this Faculty of his worth: "For many years Dr. Perry was engaged in the active practice of his profession, and in our associations with him in the practice of medicine and socially and personally, we have been impressed profoundly with his ability as a physician and his character and worth as a man. In all his medical work he was governed by the highest standard of professional ethics. He was never heard to express an unkind word of a brother practitioner and he was ever ready to lay aside personal comfort to respond promptly to the aid of a colleague. * * * While still a comparatively young man, he had attained a prominent standing in the profession."

He died at Hyattsville Md., on March 8th. 1907 of apoplexy in the 39th. year of his age.

The following was adopted and sent to the family of Dr. Perry:

The MEDICAL and CHIRURGICAL FACULTY of the STATE of MARYLAND having learned of the death of Dr. Van Lear Perry had adopted the following:

In the death of Dr. VAN LEAR PERRY this Faculty has sustained a great loss and it is with feelings of profound sorrow and deep regret that we can no longer count him among our active members.

He was a man greatly beloved and highly respected on account of his amiable disposition and integrity of character. As a physician "He was an honor to the profession", this was the verdict of those who were associated with him in his daily walk and conversation and knew him best. He possessed those qualities which in a physician endear him to his patients and in the work of his profession he displayed marked ability.

This Faculty can ill afford to lose members from its county societies so beloved and influential as Dr. Perry and it has read with great satisfaction the Resolutions passed by the Prince George's County Medical Society in regard to Dr. Perry and his work.

This Faculty extends to the family of Dr. Perry its heartfelt sympathy in this hour of their sorrow and bereavement.

George Skillman Rittenhouse M.D.

was born in Ringwood New Jersey, December 23, 1856. He obtained his literary education in Philadelphia Pa. and his medical education from the Jefferson Medical College of the same city, he received his degree of M.D. from that institution in 1882. He was married but had no children. He practised his profession in Philadelphia from 1882 until 1888 when he moved to North East, Cecil Co. Md., here he continued the practice of medicine until his death. He was an honest and conscientious practitioner of medicine and had the love and respect of all who knew him.

He died at North East, Cecil Co. Md., September 23, 1906 of pulmonary tuberculosis, aged 50 years.

The Medical and Chirurgical Faculty of Maryland having learned with profound sorrow of the death of

Dr. George Skillman Rittenhouse

have adopted the following:

Resolved 1st.—That in the death of Dr. Rittenhouse this Faculty has lost one of its valued members.

Resolved 2d.—That this Faculty feels very deeply the loss of any of its members who reside outside of the city and it can ill afford to lose the work and influence exerted by such members.

Resolved 3rd.—That this Faculty extends to the family of Dr. Rittenhouse its sincere sympathy in the loss they have sustained.

Resolved 4th.—That a copy of these Resolutions be sent to the family of Dr. Rittenhouse and a record be made of them upon our minutes.

Frank W. Schuessler, M.D.

was born September 8, 1866. He was a graduate of the University of Maryland in 1890. He died October 16, 1906 at his home, 1013 Canton St., Baltimore, Md.

Joseph T. Smith M.D., Chairman.
H. R. Hopkins M.D.
F. D. Sanger M.D.
J. E. Lewis M.D.
E. L. Whitney M.D.

MARYLAND MEDICAL JOURNAL

JOHN S. FULTON, M.D., *Editor*

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HORACE M. SIMMONS, M.D., Secretary-Treasurer and General Manager.

BALTIMORE, SEPTEMBER, 1907

THE ACADEMIC NEW YEAR.

THE silly season is past, and that of serious pursuits is at hand. Academic precincts are now in order, deans' offices open, and all things ready for the season's run of intellectual fingerlings. Thousands of these hopeful young creatures will turn cityward in the next few weeks, drawn by the lure of grown-up knowledge; and, among all the varieties of higher learning, none is more alluring, and none will enmesh the tender fry in greater numbers, than that which promises to make a young man a physician.

It is said that a distinguished professor of a past generation, on confronting a new medical class, threw up his hands and exclaimed, with dramatic intensity, "My God! What will become of you?" It is not possible that any educated teacher of medicine, in that earlier day, did not know that a majority of those who started in the way of medicine could not reasonably hope to master even the rudiments of medical science, though few of them would miss the coveted diploma, and not many would fail to earn a living income in what was called the practice of medicine. Hardly any American medical school in that day (none, so far as I know) withheld their diplomas until students were reasonably well prepared for the responsibilities of professional life. The common opinion was that the only way to learn the practice of medicine was to practice, but practice was not a part of the undergrat's course in medical schools. After a man had listened twice to one set of didactic lectures, consuming two years at the task, he was released from tutelage and licensed by his teachers, over their signatures, to get his practical training anywhere and anyhow, at the expense of a confiding public. The medical education of that day was contemptible, and many middle-aged men remember it with contempt. Two classes of students took the medical training of that day seriously, the very young and the very ignorant. But the teachers of that day were not very young, and many of them were not ignorant. It is, therefore, quite conceivable that a professor of medicine, having much experience, and more knowledge of medicine than could be imparted in 75 hours of speaking, might call God to witness that his responsibilities, in the presence of a hundred or so young men, were greater than an honest man could bear. Such conditions as these were better, however, than those of a generation or two earlier, and the conditions of medical education at present are still better; a little better, but not good enough to guarantee a well-trained and diligent young man a fair chance to become a competent physician in any medical school to which circumstances may lead him. Even now a well-educated young man, entering a medical college, may find himself in company with a lot of poorly-educated men, and under the tutelage of another lot of poorly-educated men. He may make his way up out of such a ruck, but the chances are against him. The great obstacle to medical education in the old days was the absence of preliminary require-

ments. The teaching and the examinations were graded down to a plane so low that a well-educated student could not recall anything in his past experience at all comparable to it. There was no release from the dead weight of the ignoramus and the blockhead. Nowadays there are preliminary requirements. Every school publishes its preliminary requirements, and in print they look remarkably reasonable and uniform. But in practice there are preliminary requirements only sometimes and in some schools, and some schools practically subsist upon the preliminary requirements of other schools. Especially do some schools draw sustenance from that elimination of the unfit which occurs in States where a State Board of Regents determines the qualifications of all who propose to commence the study of medicine in the State. Wherever preliminary requirements are maintained in this disinterested fashion, a young man may enter any medical school, with the certainty that his class will not be ballasted with ignoramuses and blockheads. But the ignoramus and the blockhead have still their chance. They can go to another State, almost any State, where the schools are sole judges of the student's preliminary training, and can find without difficulty a school which exists, or perhaps two schools which compete, for the relief of just such necessities.

The main advantage of the latter-day student over his predecessors is that he can find medical schools in which the study of medicine may be pursued under favorable conditions. If he goes amiss in his choice of a school, his situation is quite as unpropitious as ever. The unfit are not so fairly distributed as in former days, when practically all medical classes were of low average ability.

The interests of the public are now much better guarded, for it is nothing like so easy as formerly to get into practice. The examining boards are necessary, and often good defenses of the public health. But they have little power to influence the selection of medical students. Somewhat over halfway down the scale of medical schools are those which practice no discrimination at the beginning of the medical course, but eliminate students rather freely in the last two years. In other words, they dispose of their derelicts only after the last ounce of salvage has been effected. But the results of State examinations continue to show that illiterate men are still graduated in considerable numbers. It is still possible, as it was 25 years ago, for a man whose preliminary education is less than that of the grammar school to enter medical colleges whose published announcements make a show of far higher entrance requirements, and to obtain a diploma and qualify for a State examination in medicine, though unable to write simple sentences, or to read ordinary medical literature. At the last meeting of the Medical and Chirurgical Faculty Dr. Scott read a report on this phase of the experience of the Maryland Board of Medical Examiners. He made a similar report a year earlier, and should repeat the performance every year so long as such candidates are presented. Most of us find these exhibits of illiteracy highly amusing. To a few they are irritating. The examiners have ceased, long since, to laugh at such examples of gross ignorance, and eventually the whole profession will revolt and put an end to the miserable business. The State examination has in a few years established itself as a necessary means of protecting the people against incompetent physicians. There is equal need of an examining board at the other side of medical education, to protect young men from the rapacity of dealers in medical education.

PLAGUE IN SAN FRANCISCO—THEN AND NOW.

WHAT a contrast between the plague situation at San Francisco in 1907 and the story of plague in San Francisco seven years ago! If the two situations could be compared by the number of cases, the city is worse off today than at the beginning of the former outbreak. If the occurrence of a few cases of plague is, in fact, a great misfortune, as many suppose, then San Francisco would look upon the present situation as a crushing stroke of ill luck, coming so soon after the earthquake and fire. But the present outbreak is a comparatively light affliction, while the former one was extremely grave. In the first and lighter outbreak, San Francisco's plight disturbed the peace of half the continent. The second outbreak has scarcely ruffled the calm of the city itself, and outside the city there are no signs of fear. The reason for this remarkable contrast is interesting, and happily not far to seek. The advances of medical science are not to be invoked in this connection. So far as the plague is concerned, preventive medicine had as much to offer in 1900 as in 1907. The difference between the story of 1900 and that of 1907 is immaterial, and belongs wholly to the sphere of morals. Gross moral obliquity made the outbreak of 1900 formidable. In 1907 the oriental pest lacks the aspect of fear, because the city is clad with righteousness.

It is interesting at this juncture to recall the names of the men who controlled the sanitary destinies of the State of California in 1900, and of the men who were about to gain control of the city of San Francisco. It is not necessary to print their names. Some of them are in jail and therefore famous. Some have lapsed from fame, and some are lying low till this tyranny of uprightness is passed. One member of the precious herd perished in the earthquake. Of the chief actors in that gigantic conspiracy of falsehood only one has saved enough of his malign power to be in a small way a menace to his Commonwealth. Enormously expensive was this campaign of lying. It continued for more than two years. It bought and prostituted medical opinion; hired lawyers, reporters and detectives; sent delegations across the continent to deceive the President of the United States and to muzzle the Treasury Department. Public health officials were shadowed day and night, were flattered, wined and dined into confusion; or, these tactics failing, were juggled off the scene by orders, coming a long way round, from the seats of the Mighty in Washington. But it was not difficult for a few men some thousands of miles away to keep tally on the plague, and the truth about the lying was known to all men. The plague had to be fought even though its existence was denied. To do these two things simultaneously was impossible for any set of rascals, however accomplished. Eventually the gang was obliged to make its humble confession in public and at Washington, to promise amendment, and to transfer the situation wholly to honest hands. The epidemic of falsehood having terminated, the progress of plague was soon checked. Nearly three years were required to complete this history, and the expense was many times greater than would have liberally financed the contingency at its outset.

One may cheerfully take the risk of prophesying that the present outbreak will not cause serious loss of life, nor business depression, nor large expenditure of public funds, nor any appreciable tax upon private resources, nor quarantine, nor serious anxiety in other communities. And all this immunity is here because in San Francisco the rule of honesty has full sway.

REPORT OF BOARD OF MEDICAL EXAMINERS OF MARYLAND.

QUESTIONS AT THE JUNE (1907) EXAMINATIONS.

ANATOMY.

1. Describe the frontal bone, including its articulations and sinus.
2. Name the branches and give the relations of the external carotid artery.
3. Give relations of liver. Name lobes of liver.
4. Name structures severed by amputation through middle of leg.
5. Name and locate ventricles of brain.
6. Name the forms of inguinal hernia and give the difference between them.

SURGERY.

1. Give the cause and treatment of external hemorrhoids—(a) palliative, (b) one operative method.
2. What are the indications for operative treatment in any form of hernia?
3. What are the signs and symptoms and what is the surgical treatment of a purulent effusion into the knee joint?
4. Give in detail the treatment of a recent compound fracture of the middle third of the tibia.
5. Give the differential diagnosis between acute inflammation of the middle ear and mastoiditis.
6. Give the evidences and treatment of a wound penetrating the bladder.

PATHOLOGY.

1. Name the organisms most frequently associated with each type of pleurisy and give in detail the method of staining of each organism.
2. Define thrombosis, embolism and infarction, and name the organs in which infarction most frequently occurs.
3. Define sarcoma and carcinoma. Give the various types and the chief avenues of extension of each, and name the sarcomata in the order of their malignancy.
4. Define the term general anasarca and give a gross pathological description of the lesion which usually gives rise to it.
5. Name the varieties of meningitis from a bacteriological standpoint and describe the elements you would expect to find in the fluid from a case of the epidemic variety.
6. Give the gross pathology of amebic dysentery. Describe the organism giving rise to it and name the pathological condition of the liver often associated with it.

OBSTETRICS AND GYNECOLOGY.

1. Give treatment for case of placenta previa.
2. How would you manage a twin labor, one foot of each child presenting?
3. Diagnosis and treatment of ovarian cyst.
4. How would you treat a case of gonorrheal conjunctivitis in an infant?
5. What treatment would you adopt in a case of umbilical hernia in an infant?
6. How would you manage a posterior shoulder presentation?

PRACTICE.

1. Define (a) myxedema, (b) chlorosis, (c) tinea circinata, (d) enteritis, (e) tabes dorsalis.
2. Differential diagnosis between (a) hysteria and epilepsy, (b) cancer and ulcer of the stomach.
3. Give signs of arteriosclerosis.
4. Give symptoms of Graves' or Basedow's disease.
5. Give differential diagnosis between varicella and varioloid.
6. Give treatment of (a) uremia, (b) empyema, (c) pertussis.

CHEMISTRY.

1. Define the terms dialysis, osmosis, crystalloid and colloid.
2. Give the chemical name for cooking (baking) soda and washing soda, respectively, and state the general properties of each.
3. What, chemically, is glycerine? Give its chemical composition (formula). State its usual source and give its general properties.
4. Give in detail two reliable dissimilar tests for the detection of sugar in the urine.
5. Give the chemical composition (formula) of urea; state the usual amount excreted in 24 hours, and give in detail a reliable method for its quantitative estimation.
6. Give in detail a reliable test for the estimation of the total acidity of a specimen of gastric contents.

MATERIA MEDICA.

1. Name the mineral acids and give the dose of each.
2. What are the preparations of the phosphates and their doses?
3. What are the official preparations and doses of iodine and the iodides?
4. What are the official preparations of ergot and their doses?
5. Give the official preparations and doses of nux vomica and its alkaloids.
6. What are the principal direct and indirect emmenagogues?

THERAPEUTICS.

1. What are the physiological effects and therapeutic uses of hyoscyamus and its alkaloids?
2. Give the physiological action of nitroglycerine, indications and contraindications for its use.
3. What do we understand by the term alterative, and name the principal drugs of this kind.
4. Describe in detail the treatment for tapeworm.
5. How do disinfectants act? Name the principal ones.
6. Define local and general anesthesia. Name means and method of producing and sources of danger.

PHYSIOLOGY.

1. What portion of the gastro-intestinal tract accomplishes the greatest amount of absorption? (b) State what class of substances are absorbed in the stomach, small and large intestines.

2. What are the sources of oxygen and carbonic-acid gas in the system? (b) What is the effect of each upon the blood? (c) What is the average quantity of oxygen in venous and arterial blood? (d) What are the symptoms of insufficient oxygen in the blood?

3. Explain the effect of muscular activity upon amount and character of metabolism of body, and the influence upon this metabolism of variation in the composition of the diet.

4. What are ptyalin, pepsin and pancreatin, and in about what proportion are pepsin and pancreatin found?

5. Describe the condition known as apnea.

6. What becomes of the biliary salts which are constantly poured into the upper part of the intestinal canal? Give test for biliary salts.

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, June 18, 19, 20 and 21, 1907.

No.	College of Graduation.	Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Materia Medica	Therapeutics	Physiology	Total	Average
1	Leonard Medical, '05	..	....	58	....	64	37	53	75	54	....	....
2	Johns Hopkins, '07	81	100	73	90	78	66	92	84	90	754	84
3	George Washington University, '06	..	....	45	....	....	45	50	73	....	....	....
4	Medical Chir., Philadelphia, '03	85	85	44	90	75	57	75	89	75	675	75
5	Leonard Medical, '07	76	85	64	85	75	43	78	62	75	643	71
6	University of Maryland, '07	91	90	80	100	87	85	76	75	92	776	86
7	University of South, '07	60	....	....	....	....	52	78	82	61	....	....
8	Woman's Medical, Baltimore, '07	91	95	92	90	82	37	86	88	75	736	82
9	University of Maryland, '07	94	100	81	100	82	82	81	93	93	806	90
10	Maryland Medical '05	..	....	....	....	75	75	....	....	75	....	....
11	George Washington University, '06	93	80	90	87	82	89	79	87	75	762	85
12	Maryland Medical, '07	65	75	35	75	69	56	87	70	60	592	66
13	Maryland Medical '07	76	85	52	75	75	45	77	75	75	635	71
14	Baltimore Medical, '07	77	80	76	90	70	20	68	80	77	638	71
15	University of Maryland	91	....	....	....	....	90	91	....	90	....	....
16	Woman's Medical, Pa., '07	81	75	75	100	86	68	75	92	91	743	83
17	University of Maryland	86	....	....	....	....	86	82	....	85	....	....
18	Meharry Medical, '07	47	75	12	80	48	13	48	65	65	453	50
19	Meharry Medical, '07	60	75	22	80	45	33	42	62	75	494	55
20	George Washington University, '07	86	75	65	75	75	58	62	73	76	645	72
21	Woman's Medical, Baltimore, '07	70	90	69	95	83	49	93	88	75	712	79
22	Medical Chir., Philadelphia, '07	80	90	82	95	89	86	92	92	90	796	88
23	University of Maryland	87	....	....	....	....	83	95	....	95	....	....
24	University of Maryland	88	....	85	....	....	90	80	....	95	....	....
25	College of Physicians and Surgeons, Balto., '07	78	85	70	85	84	86	77	72	80	717	80
26	Baltimore Medical	84	....	....	....	....	83	73	....	91	....	....
27	University of Maryland, '07	79	85	92	75	80	75	84	92	75	737	82
28	University of Maryland, '07	81	85	77	100	81	89	83	89	95	780	87
29	University of Maryland, '06	62	90	76	80	77	73	84	93	90	725	81
30	University of Maryland, '07	55	85	61	90	75	75	82	87	85	695	77
31	University of Maryland	85	....	....	....	....	82	90	....	70	....	....
32	Woman's Medical, Baltimore, '07	85	80	79	85	71	76	75	85	82	718	80
33	Woman's Medical, '06	81	80	75	75	79	75	75	86	70	696	77
34	University of Maryland, '07	86	85	75	85	76	77	77	87	75	723	80
35	University of Maryland, '05	81	90	76	80	76	75	....	....	92	570	63
36	University of Maryland, '07	89	90	82	100	67	76	78	90	95	767	85
37	Johns Hopkins	77	....	....	....	....	56	90	93	85	....	....
38	College of Physicians and Surgeons, Balto., '07	85	85	71	85	84	78	78	88	71	725	81
39	University of Maryland, '07	37	85	68	85	75	50	77	77	80	634	70
40	Harvard Medical, '07	60	85	72	95	81	77	83	78	68	699	78
41	University of Maryland, '05	75	....	....	....	....	53	....	....	....	....	....
42	Yale Medical, '06	79	90	68	90	75	50	82	82	80	696	77
43	Baltimore Medical, '07	70	98	61	90	75	58	62	49	70	633	70
44	University of Maryland, '07	76	90	72	85	80	85	82	81	85	736	82
45	Baltimore University	91	....	....	....	....	93	87	....	90	....	....
46	University of South, '04	43	....	29	....	....	....	....	....	....	....	....
47	Baltimore Medical, '07	78	80	79	90	76	77	83	75	75	713	79

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, June 18, 19, 20 and 21, 1907—(*Continued.*)

No.	College of Graduation.	Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Materia Medica	Therapeutics	Physiology	Total	Average
48	University of Maryland	82	98	75	90	69	89	95	75	80	753	84
49	Baltimore Medical, '07	78	85	67	90	56	64	90	82	85	697	77
50	College of Physicians and Surgeons, Balto., '07	80	100	82	100	93	85	88	92	76	796	88
51	Jefferson Medical, '06	67	90	46	100	62	49	80	76	80	650	72
52	University of Maryland, '07	69	85	55	100	75	37	80	61	60	622	69
53	Baltimore Medical, '07	82	85	....	100	79	77	75	77	80	655	73
54	University of Maryland, '07	83	85	70	100	75	75	....	73	60	621	69
55	University of Maryland	90	....	....	....	....	95	85	....	75	....	....
56	University of Maryland, '07	85	90	70	100	72	16	83	84	75	675	75
57	University of Maryland	84	....	....	....	....	70	86	....	70	....	....
58	Woman's Medical, Baltimore, '07	61	90	50	85	75	47	80	75	75	638	71
59	Woman's Medical, Baltimore, '07	85	90	75	90	88	39	87	80	65	699	78
60	College of Physicians and Surgeons, Balto., '06	84	95	75	100	87	73	75	85	75	749	83
61	Baltimore Medical, '07	88	90	68	80	75	63	72	68	75	679	75
62	University of Maryland, '07	..	....	....	...	....	54	....	....	....	....	....
63	Baltimore Medical, '07	52	90	66	75	64	49	58	52	60	566	63
64	University of Maryland, '07	67	95	82	100	78	82	94	93	63	754	84
65	University of Maryland, '07	75	90	90	95	76	52	82	75	78	713	79
66	Baltimore Medical, '07	42	50	32	75	45	48	88	90	50	520	58
67	University of Maryland, '07	81	95	81	80	75	71	80	94	90	747	83
68	University of Georgetown, '05	75	80	65	75	84	72	85	78	75	689	77
69	University of Maryland	75	....	....	....	....	64	76	....	75	....	....
70	University of Maryland, '07	67	95	48	80	63	39	77	50	85	604	67
71	University of Maryland, '07	78	85	73	100	79	80	60	82	70	707	79
72	University of Maryland	89	....	....	....	....	87	90	....	95	....	....
73	University of Pennsylvania, '07	64	90	71	85	75	50	75	80	85	675	75
74	University of Pennsylvania, '07	82	90	85	85	94	75	80	75	95	761	85
75	University of Pennsylvania, '07	86	95	78	90	85	71	80	91	90	766	85
76	University of Pennsylvania, '07	89	98	93	95	90	58	87	86	85	781	87
77	Maryland Medical, '06	63	80	31	90	75	40	77	75	85	616	68
78	Georgetown University, '07	89	95	87	100	77	79	92	83	65	767	85
79	George Washington University, '07	88	95	66	95	87	78	85	80	60	734	82
80	Baltimore Medical, '04	76	80	60	90	77	31	77	62	65	618	69
81	University of Maryland	68	....	....	....	....	61	90	....	84	....	....
82	Baltimore Medical, '07	82	90	86	95	82	81	93	80	96	785	87
83	Baltimore Medical, '07	86	95	75	90	79	76	92	85	80	758	84
84	University of Maryland, '07	86	80	75	90	82	75	80	85	75	728	81
85	University of Maryland, '07	50	80	45	85	72	79	77	68	60	616	68
86	Georgetown University, '06	88	98	86	85	87	89	97	93	95	818	91
87	University of Maryland, '07	76	95	83	100	80	88	90	92	75	779	87
88	University of Maryland, '07	78	85	77	80	71	83	93	84	75	726	81
89	University of Pennsylvania, '07	88	95	80	90	89	67	82	83	80	754	84
90	University of Pennsylvania, '07	85	100	88	95	82	78	93	89	95	805	89
91	Baltimore Medical, '03	43	...	10	....	60	18	....	....	60	....	....
92	College of Physicians and Surgeons, Balto., '07	83	90	69	100	75	68	81	82	85	733	81
93	University of Maryland, '07	75	90	35	90	66	62	78	75	85	656	73
94	University of Maryland, '05	..	....	39	....	....	50	....	....	....	....	....
95	University of Maryland, '07	88	95	80	100	82	53	78	85	96	757	84
96	Maryland Medical, '05	48	....	32	....	54	28	....	....	....	....	....
97	University of Maryland, '07	94	90	82	100	75	90	88	67	84	770	86
98	University of Maryland, '07	89	90	88	95	89	93	97	92	95	828	92
99	University of Maryland, '07	71	90	75	90	84	40	78	87	60	675	75
100	Maryland Medical, '07	80	90	32	85	80	20	83	63	54	587	65
101	Maryland Medical, '07	38	75	49	100	68	23	78	64	58	553	61
102	University of Maryland	56	....	....	....	....	35	63	....	54	....	....
103	University of Maryland, '07	77	85	77	90	75	30	82	84	75	675	75
104	Johns Hopkins, '07	92	95	69	80	81	78	88	85	86	754	84
105	Johns Hopkins, '07	90	80	96	65	82	96	83	91	86	769	85
106	Maryland Medical, '07	8	30	5	80	48	13	68	31	46	329	37
107	Johns Hopkins, '07	80	90	91	95	78	79	85	82	79	759	84
108	Johns Hopkins, '07	72	90	84	100	83	83	82	76	70	740	82

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, June 18, 19, 20 and 21, 1907—(*Continued.*)

No.	College of Graduation.	Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Materia Medica	Therapeutics	Physiology	Total	Average
109	Johns Hopkins, '07	91	95	89	100	84	83	95	88	91	816	91
110	Johns Hopkins, '05	85	95	88	100	75	80	96	94	83	796	88
111	Johns Hopkins, '07	..	....	....	....	....	....	....	....	....	....	....
112	Johns Hopkins, '07	83	90	85	90	75	63	86	84	82	738	82
113	Johns Hopkins, '07	91	100	83	75	90	78	84	78	68	742	82
114	Johns Hopkins, '07	87	95	89	95	82	75	77	93	77	770	86
115	Johns Hopkins, '07	81	95	81	85	80	84	87	....	85	678	75
116	Johns Hopkins, '07	77	90	67	75	85	40	75	53	84	646	72
117	Johns Hopkins, '07	82	95	83	100	79	86	80	90	82	777	86
118	University of Maryland, '07	88	95	75	80	87	82	90	80	87	764	85
119	Maryland Medical, '05	27	90	11	75	63	43	92	83	63	547	61
120	Johns Hopkins, '07	87	95	92	85	91	88	80	87	73	778	86
121	Johns Hopkins, '07	94	90	93	100	93	84	80	92	87	813	90
122	Johns Hopkins, '07	81	95	87	95	85	92	88	94	90	807	90
123	Johns Hopkins, '07	64	98	91	100	90	66	97	76	86	768	85
124	Maryland Medical, '06	70	....	42	....	....	55	....	....	....	....	....
125	Johns Hopkins, '07	81	85	73	95	83	63	88	93	82	743	83
126	Johns Hopkins, '07	93	95	97	100	88	98	81	93	87	832	91
127	Johns Hopkins, '07	81	85	75	85	85	75	89	82	76	733	81
128	Johns Hopkins, '07	92	90	97	85	95	92	78	87	92	808	90
129	Johns Hopkins, '07	78	90	86	95	93	89	87	80	69	767	85
130	Baltimore Medical, '07	85	85	59	95	76	83	82	66	80	711	79
131	Maryland Medical, '05	..	....	50	....	....	....	....	....	....	....	....
132	Baltimore Medical, '06	72	85	63	75	75	61	94	85	70	680	76
133	University of Maryland, '07	..	....	....	....	....	....	....	....	....	....	....
134	Johns Hopkins	60	....	....	....	....	57	92	81	87	....	....
135	University of Maryland, '06	..	....	41	....	....	47	....	....	70	....	....
136	Baltimore University, '02	12	60	0	75	16	4	77	53	60	357	40
137	University of Maryland, '07	77	98	90	90	86	76	93	87	88	785	87
138	Johns Hopkins	62	....	....	....	....	62	87	78	88	....	....
139	Baltimore Medical, '07	42	85	31	90	64	26	90	92	66	586	65
140	Baltimore Medical, '07	60	90	66	85	75	65	93	90	75	699	78
141	Baltimore Medical, '07	80	90	81	75	80	75	95	93	86	755	84
142	University of Maryland, '07	80	85	86	95	75	70	78	75	67	711	79
143	Baltimore Medical, '05	..	....	33	....	....	56	....	58	....	....	....
144	University of Maryland, '07	85	95	69	85	83	50	95	93	70	725	81
145	Maryland Medical, '05	40	....	36	....	....	60	....	....	....	....	....
146	College of Physicians and Surgeons, Balto., '06	89	90	75	90	82	47	93	85	72	723	80
147	Howard University, '03	37	75	12	80	36	41	96	81	66	524	58
148	College of Physicians and Surgeons, Balto., '07	66	90	79	90	77	57	66	93	67	685	76
149	Johns Hopkins, '07	85	85	90	95	85	93	78	95	78	784	87
150	University of Pennsylvania	89	....	....	....	....	78	60	....	72	....	....
151	University of Maryland	87	....	....	....	....	76	95	....	81	....	....
152	Maryland Medical, '05	40	50	33	....	55	11	57	30	....	....	....
153	Johns Hopkins, '07	75	85	97	90	88	81	75	81	81	753	84
154	College of Physicians and Surgeons, N. Y., '07	92	95	68	65	84	22	75	77	75	653	73
155	University of Maryland, '07	33	....	....	....	....	37	....	....	....	....	....
156	College of Physicians and Surgeons, Balto., '07	80	80	67	95	76	60	83	63	80	684	76
157	Johns Hopkins, '03	85	98	87	100	79	98	97	100	91	835	93
158	Maryland Medical	..	....	52	....	....	40	....	....	....	....	....
159	Baltimore Medical, '06	..	75	40	....	....	52	....	62	50	....	....
160	Ohio Medical, '03	75	....	35	....	....	34	....	....	....	....	....
161	Jefferson Medical, '07	55	80	65	90	78	42	96	94	75	675	75
162	Jefferson Medical, '07	67	80	51	90	79	20	87	85	60	619	69

In the above summary an average of 75 is required of those participating in the examination for the first time in order to secure a license. Those who have failed are eligible to re-examination at the the expiration of six months. They are then obliged to receive a rating of 75 in each branch in which they are re-examined before license can be issued. Under the Maryland laws, students who at the end of their second year have successfully passed their college examination in Anatomy, Chemistry, Materia Medica and Physiology are entitled to examination by the Board of Medical Examiners in these branches. The ratings made by these students in the examination known as the "second year examination" are carried forward and made a part of the final examination, when an average of 75 must be obtained to secuse a license.

We trust that this statement will make clear the apparently incomplete examination of certain participants.

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THE GRADUATES OF THE WOMAN'S MEDICAL COLLEGE OF BALTIMORE AND THEIR WORK.

By W. Milton Lewis, M.D.,

Baltimore.

During the summer of 1905 it occurred to the writer, who was at that time the president of the Medical Society of the Woman's Medical College of Baltimore, that a review of the work done by the Woman's Medical College, as exemplified by the professional and social standing of its alumnae, might prove interesting to the friends of the medical education of women.

To this end he addressed a letter to every alumna whose address he could secure, asking for a resume of her work since her graduation, a report of one or more of the most interesting cases which she has had the opportunity of observing and finally how she has been received by the laity.

To these letters, of which 80 copies reached their destination, 26 replies were received, and *all*, with one lone exception, were written in the most cordial vein.

With the close of the 1906-07 term the Woman's Medical College has completed 25 years of successful work. Two hundred and seventy-three young women have matriculated, and of these 99 have completed their courses with credit and have received their degrees.

In the first year (1882-3) there were 19 matriculates. Of these two are classed as second-year students, and one, Dr. May R. Owen, 131 North First street, Brooklyn, N. Y., graduated in that year. One of the matriculates of that year was Dr. M. Laura Ewing-Reading, at present of Hayden, Md. In a personal letter to the writer, Dr. Ewing-Reading states that while her name does not appear first in order upon the Matriculation Record of the

college, she was, nevertheless, the first to make arrangements for the study of medicine in Baltimore.

An abstract of Dr. Ewing-Reading's letter follows:

"Hayden, Md.

"Dear Doctor—In reply to your request for a resume of my work since graduation I will say that I think my experience has been quite satisfactory. The day I graduated I took charge of a gynecological case, treated it and operated with successful result, received praise, $104 and as patients a number of my patient's friends, who also paid me well. After finishing up this work, which lasted about three months, I went to my home in the country for a rest. I was called to a fever case which gave me many anxious moments. I succeeded in keeping him alive, as also another similar case in the same house.

"I then returned to Baltimore and opened my office, receiving the appointment of assistant surgeon to the Woman's Medical College; had a fair practice in Baltimore, besides a good many patients from the counties.

"My path was not without its thorns. While the number of patients increased, so did the trials, but my success has been far in excess. I have made a living and have helped many to live without pain.

"I have done some major operative work, among which I may mention hysterrectomy. One of my cases, a fibroid tumor case, in the removal of which two of my professors aided me, was unfortunate in its final result. After two weeks the patient was able to sit up, and one month after the operation I went to the seashore for a visit. On returning I found my patient had died suddenly. Relatives said they had sent for a doctor, but she died before he came. I could not get a satisfactory account of the cause of her death."

Another matriculate of that year was Emily W. Fifield, now located in Minneapolis, Minn., and engaged in special work in gynecology. Dr. Fifield spent several months in Baltimore a few years ago working in the Johns Hopkins Hospital and in Dr. Simon's clinical laboratory. Harriet B. Jones of Wheeling, W. Va., who matriculated during the same year, was the first woman president of the West Virginia Hospital for the Insane in Weston, W. Va. Dr. Jones enjoys a lucrative general practice in Wheeling.

In the fall of 1884 India M. Cochel was among those enrolled. She writes that her training has sufficed, with but little reviewing, to enable her to pass the Massachusetts State Licensing Board after a lapse of many years. She conducts a sanatorium at Aroostook Springs, Ashland, Maine, in a most beautiful location.

In the sixth session (1887-8) we find many familiar names. Perhaps the most prominent of these is that of the present incumbent of the chair of pathology in her alma mater, Claribel Cone. No less an authority than the renowned pathologist Dr. W. H. Welch has said that Dr. Cone occupied the first position among

women pathologists. Many scientific papers have come from her pen, and she was one of those asked to contribute to the memorial volume upon the occasion of Dr. Welch's twenty-fifth anniversary. She has been for several years in Europe studying under great masters, and is expected to return to her work in the Woman's Medical College this fall.

Dr. Donna Ann Waldron of the same class has been in successful private practice since graduation. Dr. Waldron has allied herself with homeopathy, and has been connected with the Homeopathic College since 1893.

In 1889 Dr. Fannie S. Hoopes, D.D.S., entered as a student of surgery and later took up the regular medical course. Dr. Hoopes has devoted herself to oral diseases in connection with dentistry and is very successful.

In 1890 there were 22 matriculates, four of whom are well remembered by the writer. Edith Eareckson, Ida Pollack, Anginette L. Fowler and Tertia Claire Wilton. Drs. Eareckson and Ida Pollack were for several years connected with the teaching staff of the college, and Dr. Pollack was resident physician of the hospital of the Woman's Medical College 1894-5. Dr. Pollack later married Dr. E. J. Bernstein and now lives in Kalamazoo, Mich. She has retired from active practice.

Dr. A. L. Fowler-Noble is now in private practice in Westfield, Massachusetts.

In the tenth year (1891-2) there were 27 matriculates. One of these, a graduate of pharmacy, was admitted to the senior year. Amelie M. Fendler, Ph.G., M.D., occupies a most unique place among women practitioners. Besides attending to a lucrative private practice, she has been appointed expert medical consultant to the courts of New York. Dr. A. M. Fendler graduated from the New York College of Pharmacy in 1889, Woman's Medical College of Baltimore in 1892, passed a civil-service examination, attaining an average of 94 per cent., and was appointed medical inspector of the New York Health Department. She is connected with the department of pediatrics at Mt. Sinai Hospital. Dr. Fendler reports a case of accidental hemorrhage, which is of interest because of the unique autopsy findings in the fetus.

Brief History.—K. G., aged 30, five feet two and three-quarters inches in height, weight 131 pounds; has had three children, no miscarriages; always good health; no specific history; first two deliveries instrumental, third spontaneous.

On July 17, 1905, at 12.30 A. M., the doctor was hurriedly summoned and found Mrs. G. having severe hemorrhage, being at the end of the eighth month of gestation. Pains were absent. The patient was put to bed, hips raised, tamponed, and quinine and whiskey in full doses administered. The bleeding continued, the pulse became rapid and feeble, with profound anemia, with no elevation of temperature. Upon removal of tampon 12 hours later the os was found slightly dilated and labor pains coming on; the

dilatation was completed manually, forceps applied and the labor promptly terminated.

Description of Fetus.—Externally the only indication of an anus to be seen was a dimple just anterior to the coccyx. The testicles were undescended. The large and small intestines were supported by a *common* mesentery, and the ascending colon was found upon the *left* and the descending colon upon the *right* side of the abdominal cavity. The sigmoid is short and empties into a large ovoid sac just opposite the brim of the true pelvis. This sac represents both bladder and rectum and fills the pelvis, extending almost as high as the umbilicus. At its base, posteriorly, it presents two small pouchlike protrusions, or saccules, each about the size of an English walnut. The sigmoid and right ureter empty into the *right*, the left ureter into the *left* saccule. There is no rectum proper, the perineal dimple being connected with the sac just described by means of a tiny canalized structure (10 mm. long, 4 mm. wide) which is obliterated at its distal end. The intestines, as well as the sac, are filled with a dark red-brown bloody semisolid material.

Louise Eaton and Sue Radcliff also entered in 1891, both in the first-year class. Drs. Eaton-Seebur and Radcliff organized the Lying-in Hospital of the Woman's Medical College, Dr. Eaton-Seebur being particularly interested in that work. Ella J. Reed, sister of Dr. Boardman Reed of Atlantic City, and who afterwards married Dr. J. F. Martenet, also entered the school in 1891. Dr. Reed's untimely death a few years later, followed so soon by that of Dr. Martenet, has left a vacancy among the practitioners of East Baltimore which will long remain.

Of the matriculates in the year following (1892-3), Louise Erich's name is best known to Baltimore physicians. Dr. Erich was the daughter of Professor Erich, for many years connected with the College of Physicians and Surgeons of Baltimore. Dr. Erich's fine work in orthopedic surgery will endear her to her colleagues and pupils.

Among those entering during the session of 1803-4 were two whose homes are now in that far-off land where but recently the mountains, valleys and plains were stained red with the life-blood of Russian and Jap alike. Dr. Kate MacMillan and Dr. Mattie Ingold-Tate are located as medical missionaries in the Hermit Kingdom, Dr. Ingold-Tate at Cheufu and Dr. MacMillan at Wonsan.

In 1894-5 37 ladies matriculated, 24 being in the junior class. Among those entering upon the first year's work in 1894 was one who stands out prominently among her classmates as one of the most practical and successful women who has been graduated from the Woman's Medical College. Dr. May Farinholt-Jones has been since her graduation—now 10 years—the resident physician of the Mississippi State Industrial College, an institution which shelters and educates over 700 young women annually. Dr. Jones had charge of the hospital of the Woman's Medical College during

the summer after her graduation and did splendid work among the typhoid-fever cases brought home from the Spanish-American War. Dr. Jones is now studying in Europe. Her letter seems of sufficient interest to be reproduced verbatim:

"Dr. W. M. Lewis, Baltimore, Md.:

"My Dear Doctor—When you asked me several weeks ago to give you a brief paper, in the form of a synopsis of my professional work during the past eight years, I scarcely thought then that I would be sending you a letter at the last moment, giving you a very detached outline of this period, which to me has been one of such vital interest.

"My only excuse—and I am sure you will extend pardon—is that at no time since I saw you have I been sufficiently settled to collect the work of the past eight years in a readable form; then, too, I am sure you will agree with me that the average woman writes a better letter than a so-called paper.

"Eight years ago when I joined hands with Esculapius for a walk down the 'long path' my armamentarium was heavily weighted with three things—egotism, energy and enthusiasm. If this enthusiasm is a little less keen and the energy less equal to all the tasks to which ambition fain would point, the egotism is a thing of the past, sleeping with the care-free, irresponsible days of student life.

"In thinking it over I find your question, 'How are women physicians received by the laity?' a difficult one to answer. My position as resident physician in the State College, which is supported by the Legislature, makes one, as a physician, somewhat independent of the opinion of that great majority which we term the laity. The physician here is approved and signed with the seal of the Governor, the board of trustees and the president of the college. The institution draws its patronage from rich and poor, from the homes of plebeian and aristocrat alike. The college uniform levels all ranks. The daughter of a town policeman has the same attention and privileges as the daughter of the United States Senator and ex-Governor. I was fortunate in having no predecessor. In the first few years of my residence here some of the parents felt some anxiety and lack of confidence in the 'lady doctor,' as they would persist in calling me. That feeling has been entirely overcome, and parents frequently tell us that they send their daughters here that they, in case of illness, may have a woman physician.

"Among some classes I can give you the opinion of the woman physician in one brief sentence, a comment made by an old countryman when he heard a gentleman here speak to me as 'Dr. Jones:' 'Sir, what did you call her?' And when told, he thought his ears had played him false. 'Well, sir, I would as soon call a niggar mistah as to call a woman a doctor.' That was the worst thing that a Mississippian could ever have to do.

"Mississippi was virgin soil to the woman physician when I came here eight years ago, and that a pioneer would suffer a little

was but natural. In the words of the poet, the good people the laity have pitied, then endured and then embraced. I am frequently urged to take certain cases in families or to take the family practice.

"The profession in the State have been more than kind. They have met me in consultation, called on me to help them and honored me with the vice-presidency of the State Association.

"I repeat I am really not in a position to give you anything on this subject, having the good fortune to be a health officer of a State institution, the office ranking socially and professionally with the best in the Commonwealth.

"Institution work has its drawbacks as well as its privileges—the old law of compensation as you know.

"The work is anything other than monotonous, as you may well imagine, with each year over seven hundred people coming under one's professional care. Hygienic and sanitary conditions must be vigilantly cared for, in fact, eternal vigilance along this line is the watchword.

"We have our quota of the little 'ills to which the flesh is heir,' the nagging ones that puzzle us and a few malingerers. However, I must say, when we consider the large number here this last mentioned disease is rare. We do have a disease that occurs on the seventh day of the week only and is entered on our records as *morbus sabaticus;* at times it is almost epidemic; it is peculiar to schoolgirls and boys only.

"Typhoid fever, of which our records show 68 cases, has given us some interesting work. Pneumonia, with 10 cases to its credit, one followed by emphysema and resection; one case of rheumatic endocarditis, several cases of appendicitis, 214 cases of measles in one epidemic, several epidemics of la grippe with its usual train of sequelae and last, but by no means least, malarial haemoglobinuria have furnished food for thought and sleepless nights. One case of special interest is a patient with an inguinal hernia in which the ovary is included, the *hernia* due, I take it, to the wearing of a peculiar tight and ill-fitting hose supporter.

"I may mention another patient of mine, a girl 19 years of age, healthy looking young woman weighing 150 pounds, who came to me saying she had never menstruated. On examination I found complete atresia; labia fairly well developed, but complete absence of vagina, uterus, etc. Patient nervous, because she worried over the fact that she did not menstruate.

"Having my duties here concentrated and systematized, and having a corps of efficient trained nurses, gives me ample time for study and laboratory work. This is both interesting and profitable, as I do the microscopic clinical work for many of the nearby physicians.

"Some part of my three months' yearly vacation is spent in study, either in hospitals or laboratories. Sometimes with bated breath and softened tread I have followed Osler through the wards of the Hopkins or else it has been to watch the deft fingers

of some of the surgeons in the Charity Hospital in New Orleans or to glean in some laboratory findings helpful to the student.

"I was invited last June to come to the Charity Hospital of this State, located at Natchez, to do the urinalysis for the hospital, having at same time given unlimited freedom in the operating room, medical wards and autopsy room—privileges that carry quiet opportunities for study and research.

"Many interesting cases presented themselves and in passing I mention two briefly, viz.; Andrew W., negro, 67 years of age, sent in for emergency operation with a diagnosis given the ambulance surgeon of strangulated hernia. An incision made in tumor-like mass, near McBurney's point, showed a gangrenous appendix walled off in a sac and with it 115 plum seed; the stench from the wound and stone quarry was simply fearful; peroxide and sterile water was poured in by the quart; incision left open; patient made an uneventful recovery. Later he gave history of having eaten the plums two weeks before.

"Case 2 was a man 72 years old, admitted from Louisiana, thought to have some kidney trouble, but before the urine could be obtained and examined patient sunk into deep coma, breathing stertorously, and death seemed imminent. Examination of the blood showed it swarming with pernicious tertian malarial organisms. Coma lasted 48 hours, and even with 60 grains of quinine administered hypodermically daily for a period of two weeks the organisms were still numerous in the peripheral circulation. He recovered after several weeks. He only had the one chill after coming to hospital.

"In this same ward we had carefully double-screened a patient with yellow fever and from whom I made numerous blood examinations.

"This is the third time in my eight years' residence that the quarantine has prevented the opening of our school and hospital, but this is the first time that I have been caught within the quarantine lines.

"Fearing that my letter is growing rather lengthy, I will close by wishing for the new students the happiness in their chosen profession that I have found (more I cannot wish them), and to my Alma Mater and to the earnest, enthusiastic men and women who are caring for her progress my heartiest congratulations for what has been accomplished, and cordial wishes for a continuation of that success which is so justly hers and theirs.

"Your friend, sincerely,

"October 20, 1905." "May Farinholt Jones, M.D.

Among those entering in the year 1895-6 was Mary A. Waters, daughter of Dr. E. G. Waters, a well-known physician, from whom Ian Maclaran might well have copied the famous character of Dr. McClure. Dr. Mary A. Waters has been upon the teaching staff of her Alma Mater for many years and is its faithful dispensary physician.

With the fifteenth year came the beginning of the four-year course in medicine, and of those who entered then four are well remembered by the writer—Esther Kim Pak of Seoul, Korea, and M. Annie Howe and Willena A. Peck of Massachusetts and Sara A. Castle of Mississippi. Dr. Pak is now in the Far East, but having very poor health. She has had a very varied career. Dr. Pak had a very sad ending to her medical course, for as her final examinations were about to begin her husband, whom she had nursed at night, doing her lectures and laboratory work during the day, died of tuberculosis. Notwithstanding this considerable handicap, she passed her examinations very creditably.

"Chefoo, China, October 4, 1905.

"My Dear Dr. Lewis:

"Yours of July 1 reached me in September. It had been delayed on the way so long that I failed to get it in time to write you anything about my medical work since my graduation. Soon after I received your letter I had to come away from my work for a rest to seacoast. My health has been poor nearly all the summer long, but I kept on with my medical duties until I was compelled to go to bed with fever and every symptom of pleuritis acute, which has left my lungs rather delicate, and signs of phthisic evident and marked emaciation and heart complications, so I had not been able to do anything since early July. Chefoo is a summer resort—a beautiful seacoast indeed. I have improved a great deal since coming here—salt air seems to be helpful. I have gained a little in weight. I feel deeply grieved to think that I am a victim of such dreaded disease. But the Lord has been good to me; I feel I am going to get well again.

"I am exceedingly sorry that your letter was delayed so that an account of my work here will be of no use to you by the time my letter reaches you. However, I hope you have received a favorable letter from Drs. Ingold and McMillan. Dr. McMillan lives in Wonsan and Dr. Ingold (Mrs. Tate) lives in Cheuju. Dr. Ingold married Mr. Tate soon after her return from America. It seems like old times to hear from you. Your letter made me real homesick for dear old W. M. C. and all the kind professors. How I used to enjoy the catalogue of W. M. C., which I do not receive any more! I have often wished to be able to drop in to hear some of the lectures. I grow weary sometimes in my work and often longed for a good talk with some of the kind teachers and consult about some of my perplexing cases, but I suppose such luck will never fall to my lot.

"Medical practice in Korea is not a lazy one by any means. We doctors here have to work under most difficult surroundings. One cannot possibly imagine the situation. Both of us are as busy as we can be with our patients. We have a full clinic every day, besides our in-patients. I have one assistant in the dispensary and we have two helpers in the hospital, besides our outside man, and the capacity of our hospital is a good deal larger than G. S. H.

of your college. We have no trained nurses to help us in our operations. I prepare all myself, and we two operate as best we can, and we usually have good results. We may not have all the modern instruments and trained nurses, but we do the work. Dr. Hall does most of the operations with my help. I have never operated alone yet.

"We had several very successful vesicovaginal fistula operations. One young woman had it for six or seven years. Our first operation did not help her as much as we hoped, but the tenth operation cured her completely. Another case of an old woman who had traumatic vesico-vaginal fistula for many years, her entire bladder being diseased, torn and contracted, went home completely cured after a single operation. This old woman, aged 68, had procidentia for many years. Some quack advised her to have it burned out. The result was sloughing of bladder wall and its surrounding tissue. Burning is most common treatment for such ailments by the natives and we have to cure the consequences. We had a number of cases of atresia, as well as fistulae from such treatment. The natives have very odd ideas about drugs. For retained placenta fish scale is tied on the sole of the patient and caster oil plant is placed near her head.

"I have been called to a case once where they fed a child with bedbug cooked in oil to cure convulsions. We have to work against these ignorant ideas. It is very trying on our nerves. Never heard of dieting the patient in Korea. Child who has severe hemorrhage from the bowels, if child wanted it, mother gives raw chestnut and corn, candy and everything child happens to wish, so you can readily see how hard it is to practice among them.

"I could give you many such cases, but my letter has grown quite lengthy, so I shall close for this time. I wonder whether you will be able to read my poor English? Since coming home my English is getting poorer each year, for I use more Korean than the former.

"I hope you will pardon me for taxing your courtesy in reading such tedious scribble.

"I remain as ever your sincere pupil,

"Esther K. Pak,
"Pyeng yang, Korea."

Dr. M. Annie Howe-Anthony, now residing in Moravia, New York, has frequently returned to the city to visit her Alma Mater. Her letter is given in full:

"Since leaving college my work has covered a wide range of cases, and has also been carried on in different parts of the country. After graduating in Baltimore a very helpful and pleasant year was spent at the hospital of the Woman's Medical College, a year that gave me most valuable experience in general medical cases, in surgical work and obstetrical practice. Later I spent a year at the Markleton Sanitarium, in Markleton, Pa., a sanitarium for

nervous diseases only, such as neurasthenia, chorea, hysteroepilepsy, migraine, asthma and various forms of neuralgia. Here I was the only woman physician. I had charge of all the laboratory work, for which I was faithfully drilled by the painstaking president of the Society of the Woman's Medical College of Baltimore. The electrical treatment was also confided to my care, various forms of static, galvanic and faradic electricity that were at that time all new to me. By the aid of books I was able to take it up, and through study and practice I have become much interested in the subject.

"The gynecological work also fell to my care, and here again the teaching of Dr. Browne was ever of the greatest assistance to me. The year at Markleton was an interesting and happy one, for there a woman physician was always honored and treated with the greatest respect.

"For over two years I have been assistant physician at Dr. Given's Sanitarium, Stamford Hall, Connecticut, which receives cases of nervous disease, mild cases of mental disease, persons addicted to the use of drugs and alcohol, together with a certain number of medical cases such as pernicious anemia and rheumatism. It has been my good fortune to treat a great varietry of abnormal conditions. There have been many cases of mania, melancholia, paresis, manic-depressive insanity, dementia praecox, paranoia, mental and nervous diseases following the abuse of alcohol, chronic alcoholism, cocaine, morphine, heroin, chloral and opium addiction. Excessive cigarette smoking has also required medical treatment in certain instances. A case of brain tumor proved an interesting study. At Stamford Hall there are on an average two hundred and twenty patients, their cases covering a wide range of pathological conditions.

"In regard to the way women physicians are treated in the world at large I can certainly affirm that they receive courtesy everywhere.

"M. Annie Howe."

Dr. W. A. Peck is in Blue Mountain, Miss., as resident physician in a large school. She has had the opportunity of spending parts of several vacations in Baltimore in study. Dr. Sara Allen Castle was also a member of this class. She has also graduated from Columbia, and was for some time resident physician in a school in Meridian, Miss. She is now in private practice in that city, has a private clinical laboratory and is City Bacteriologist.

Of those entering in the years 1897-8 there are at present on the teaching staff Drs. Voeglein and Willis, both engaged in private practice in this city and both successful. Dr. Mary Lois Jones is in private practive in Pittsburg, Pa.

In the year following Annie C. Shipley entered the school and proved one of the best workers in pathology. Dr. Shipley has engaged in private practice at Seaford, Del., and has been successful.

Elma Jones-Townsend entered advanced work in January, 1898.

Dr. Townsend states that directly after her graduation from the Woman's Medical College of Baltimore in 1899 she returned to her home in Madison, Wis., and found a call awaiting her. About the beginning of 1904 Dr. Townsend removed to Hartford City, Ind., having purchased the practice of Dr. C. F. Sexauer of that place. Her income now approximates $3000 per year. Perhaps the most important case, from a scientific standpoint, was one of nervous degeneration from nicotine poisoning, which was reported before the Dane County Medical Society of Wisconsin.

Among those entering the session of 1899-1900 were three daughters of physicians—Jennie and Mary Browne, daughters of Prof. B. B. Browne, and Charlotte S. Murdoch, daughter of the late Dr. Russell Murdoch. Dr. Mary Browne was for several years upon the teaching staff of the college. Dr. Jennie Browne is professor of physiology, and both are engaged in private practice. Dr. Mary Browne has reported an interesting case of tubal pregnancy in which the patient had attempted to produce a criminal abortion. Dr. Charlotte S. Murdoch-Young is at present in the interior of China with her husband, where both are engaged in medical missionary work. Dr. Murdoch-Young spent some time in study in Baltimore after her graduation, taking up district and parish work, after which she went to England and was associated with Dr. Campbell Morgan in London. She spent a few weeks in Baltimore last winter, and spoke on parish work in London at the twenty-fifth anniversary exercises of the Woman's Medical College, February 24, 1907. She married Dr. Andrew Young of Glasgow, Scotland, in Shanghai, China, in April, 1907, and is now located in Hfi-an-fu, Shensi, China.

Another matriculate of the same year was Susan A. Price, who has been "woman" resident in the West Virginia Insane Asylum for the past two years. Dr. Mary Cook of the same class is located in Newark, N. J., and engaged in private practice.

In 1900, Henrietta M. Thomas, daughter of Prof. Richard Henry Thomas, for many years professor of diseases of the nose, throat and chest in the Woman's Medical College, was one of the matriculates. Dr. Thomas spent the last two years in England and France, and engaged in post-graduate study. She has charge during the summer of the pediatric clinic in the Johns Hopkins Hospital Dispensary, and is the bacteriologist of the Woman's Medical College.

Dr. M. A. Seiler is in Key West, Fla., and is succeeding very well. She is spending much time in the study of malaria.

Dr. E. B. Sterling, who finished her course in the following year, is devoting her time largely to orthopedics, and has spent much time in the hospitals of Baltimore and other cities in the study of that subject.

Of the next year class, Dr. L. G. Miller, who has spent the past year as woman resident of Eudowood Sanitarium, Towson, will take up private practice in the Far West in the not very distant future. Dr. Lida F. Allen, who entered the school a year later as

a second-year student, is now resident physician of the Jewish Maternity Hospital of Philadelphia, Pa., and finally, of the last class graduated, two members, Dr. Lois Boyd and Dr. Hilda Fletcher, have already received appointments, Dr. Boyd in the Winthrop Normal and Industrial College, South Carolina, and Dr. Fletcher in the West Philadelphia Hospital in Philadelphia. Drs. Bertha E. Tapman and Emma F. Campbell have appointments upon the dispensary staff of the college, and Drs. Carrie B. Erdman and Daisy C. Hoffnagle expect to enter into private practice.

As to the position occupied by women in the field of medicine, and in reference to the relation existing between medical women and the laity, the writer begs to quote from a letter received from Dr. A. M. Fendler of the class of 1892 as follows:

"The laity have always received me well—all classes, rich, poor and middle. Any opening doubt I have always endeavored to dispel by a thorough conscientious attention to my duty as a physician and the putting of the best that was in me into each individual case. The woman doctor is a necessity, she is here to stay. Each year recognizes her field of usefulness more."

Book Reviews.

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially-Prepared Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and Other Topics of Interest to Students and Practitioners by Leading Members of the Medical Profession Throughout the World. Edited by W. T. Longcope, M.D., Philadelphia, with the collaboration of William Osler, John H. Musser, A. McPhedran and others, with regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels and Carlsbad. Vols. II and III. Seventeenth series. Philadelphia and London: J. B. Lippincott Company. 1907.

In these two volumes this excellent Quarterly fully maintains its standard. The 50 separate articles cannot possibly appeal equally to any reader, but each volume gives ample reward to its purchaser. One can only mention a few of the articles, and the discrimination among them is necessarily unfair to the corps of contributors, though just to the series. In each of these two volumes the first article wins a mention, that on "Vaccine Treatment of Infectious Diseases," by Rufus I. Cole, and that entitled "Some Practical and Theoretical Considerations Concerning Diabetes," by David L. Edsall. Other articles which proved most interesting to a single reader are a very conservative paper on "The Curability of Tuberculosis," by E. S. Bullock (a necessary counterblast to the overenthusiastic papers on this subject); an article by Leo Loeb on "Inoculability of Tumors and the Endemic Occurrence of Cancer;" "Atophomenorrhea," a discussion of vicarious menstruation, by F. K. Green and Q. W. Hunter; "The Management of Exhaustion States in Men," by J. Madison Taylor; "Gonorrhea and Syphilis in Infancy and Early Childhood," by Thomas Morgan Rotch. Another reader would select another and a different set of articles from the same two volumes and name them as the sources of his particular satisfaction with the current series.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

COUNTY SOCIETY MEETINGS.

FREDERICK COUNTY.

THE Medical Society of Frederick County met at Kemp Hall, Frederick, Wednesday, August 12, at 12.30 P. M.

In absence of President Downey, Ex-President Dr. E. L. Beckley presided.

There were present as visitors, Dr. Charles O'Donovan, President of the State Society, Ex-President, Dr. Hiram Woods, District Councilor, Dr. Wm. P. Miller of Hagerstown.

The report of the Treasurer showed that all members on roll, which numbered forty-seven, were fully paid. Thirteen applications for membership were received.

Dr. Charles DuFour of Washington gave a very interesting paper upon the new "Surgical technique" of throat and bronchial work.

The next regular meeting will be held in November at which time the annual election of officers will occur.

The meeting adjourned.

ALLEGANY COUNTY.

THE Allegany County Medical Society met in its new home in Cumberland, September 4th.

Dr. Charles O'Donovan, President of the State Faculty was present and gave a very interesting as well as instructive talk.

At this meeting the post graduate work as suggested by Dr. McCormick was inaugurated, the subject under discussion being "Carcinoma of the breast."

This was the first meeting the society has held in its new home.

CAROLINE COUNTY.

THE Caroline County Medical Society held its third quarterly meeting in Preston, September 12. Interesting talks were given by the following:

Dr. H. C. Davis of Baltimore on "Adenoids."

Dr. Guy Steele of Cambridge, on "Pneumonia."

Dr. P. L. Travers on "Hospital work."

There were present but seven of the members of the society, which was caused partly by the physicians being so busy.

Four new members were added to the Society, *viz:* Drs. S. S. Stone and J. C. Madara, of Ridgely, Dr. F. Silver, of Goldsboro, and Dr. J. R. Phillips, of Preston.

The next meeting will be held in December at Denton.

MINUTES OF THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY, SEPTEMBER 11-14, 1907.

HOUSE OF DELEGATES.

The nineteenth meeting of the House of Delegates was held at the Faculty Hall, Wednesday afternoon, September 11, at 4 o'clock, the President, Dr. Charles O'Donovan in the chair.

Dr. W. Edward Magruder, the Assistant Secretary, served in the absence of the Secretary, Dr. John Ruhräh.

The following members were present: Drs. H. Bratton, S. J. Fort, N. Dudley, Paul Jones, Charles O'Donovan, H. W. Cushing, J. E. Gichner, W. P. Miller, W. S. Gardner and W. E. Magruder.

The minutes of the House and Council were read and approved.

Dr. John D. Blake, Chairman of the Committee on Public Policy and Legislation, reported on the matter referred to that Committee by the House of Delegates at the annual meeting in April for presentation at the semi-annual meeting, and, if then deemed advisable, to be taken before the next Legislature.

First: "The consideration of the Medical Practice Act as revised in 1905 by the State Board of Medical Examiners and a special committee of the Faculty."

Second: "That the laws submitted by the Midwifery Committee be thoroughly considered and that a law regulating the practice of midwifery be drafted for presentation at the semi-annual meeting."

Dr. Blake, as chairman, recommended the advisability of presenting a new Medical Practice Act, but thinks it better to have no midwifery law than one which cannot be enforced.

Dr. Gardner moved that both laws be let alone for the next term of Legislature, and that the Legislative Committee be relieved of responsibility for legislation at this time. Seconded by Dr. Miller.

Discussion by Dr. Gardner who stated that we have a fairly good law and that it should not be amended until we try this law longer and the various incidentals relating to reciprocity between states have been worked out by the Examining Board, after which we will be much more likely to get a satisfactory law.

Dr. Dudley stated that the midwifery law is one of the most important questions confronting us. He thinks there should be a law requiring registration of midwives.

Dr. Blake desired to hear from county members as to what law they think could be passed to help matters.

Dr. Bratton said that the deaths reported were in excess of births in his county.

Dr. Fort thought local laws might be passed for the counties as game laws have been done, and not a state law.

Vote on Dr. Gardner's motion taken and carried. Committee continued.

Dr. O'Donovan stated that the Archer family had offered to have a portrait of John Archer painted and presented to the Faculty for its presen-

tation to the Governor to be hung in the State House at Annapolis. He also stated that efforts were still being made to collect money for a new building and report would be made at a later date.

The following amendments to the Constitution of the Faculty introduced at the meeting of the House of Delegates during the annual meeting of the Faculty, April, 1907, were read, and will be voted on at the annual meeting of the Faculty, April 1908:

Article 5. Amend by adding the words "No member of the State Examining Board shall be a member of the House of Delegates, except the secretary who shall be a member ex-officio."

Article 5. Further amend by inserting in above amendment after the word "Board" the words "or the delegates to the House of Delegates of the American Medical Association," and after the word "secretary" the words "of the Board."

Article 6. Amend by adding the words "No Councilor shall be eligible as a delegate of a component society."

Article 9, section 3. Amend as follows: "The officers of this Faculty shall be nominated by the House of Delegates at the second meeting of that body and shall be elected on the morning of the last day of the annual session."

The meeting adjourned.

GENERAL SESSION.

The semi-annual meeting of the Medical and Chirurgical Faculty was held on the steamer "Charlotte" which was chartered by the members of the Committee on Arrangements to take the party down to Norfolk and back and be their headquarters while there. The trip allowed for two full days and one night at the Jamestown Exposition, the boat leaving Baltimore the night of Wednesday, September 11, 1907, and returning Friday night, September 13. Thursday, being September 12, the members participated in the Maryland-Day Celebration to which cards of admission were provided.

Scientific sessions were held on board boat.

The first session was called to order by the President, Dr. Charles O'Donovan, Wednesday evening, September 11 at 9 o'clock.

The program was carried out as follows:

President's address—Dr. Charles O'Donovan.

The philosophy of disease—Dr. Wm. H. Pearce.

The effort to prosecute unregistered practitioners of Baltimore City—Dr. Herbert Harlan.

Acute pyelitis due to acute appendicitis—Dr. Guy L. Hunner.

After adjournment refreshments were served in the dining-room by the Committee on Arrangements.

The second session was held Friday evening, September 13, at 9 o'clock, the President, Dr. O'Donovan in the chair.

The following papers were read:

The operative treatment of cancer of the stomach, with report of cases—Dr. Jos. H. Branham.

Discussion by Dr. Watson.

Psychotherapy in the treatment of functional neurosis—Dr. A. P. Herring.

Discussion by Drs. Preston, Anderson and Herring.

Should prisoners deficient either mentally or physically be tried in our Courts of Justice—Dr. Theodore Cooke, Jr.

Discussion by Drs. Preston and Cooke.

Dr. Herring stated that there were fifty thousand dollars in hand for the new building and the Committee would keep on working.

The following resolutions offered by Dr. Watson were adopted:

"Resolved, by the members of the Medical and Chirurgical Faculty that this semi-annual meeting now drawing to a close has been unique in the history of the Society in the matter of social features, in the promotion of acquaintanceship and good fellowship amongst its members.

"Resolved, that our thanks be given to the members of the Committee on Arrangements for their exceedingly effective labors in our behalf.

"Resolved, that the members of the Medical and Chirurgical Faculty express their appreciation of the courtesies extended to them during their trip to Jamestown by the Chesapeake Steamship Company, and of the personal attention given to our pleasure and comfort by Mr. Edmunds Foster.

"Resolved, that the thanks of this Faculty be also given to Mr. Barrett, President of the Buena Vista Spring Water Company for providing the spring water used upon the trip.

"Resolved, that the Secretary be instructed to send these resolutions to the above named parties."

The meeting adjourned.

PRESIDENT'S ADDRESS.

Dr. Charles O'Donovan.

Fellow Members of the Medical and Chirurgical Faculty of Maryland, Ladies and Gentlemen:

It seems most proper that this address of your President should open with sincerest congratulations upon the large attendance at this semi-annual meeting, a result due in large measure to the foresight and energy of your Committee on Scientific Work and Arrangements who conceived the idea of holding the meeting in this pleasant manner, and, after approval by the Council, infused into the undertaking so much of their inherent enthusiasm as to produce this striking success. Your President feels confident that the result will amply justify the undertaking, and will serve as an evidence of what the Faculty can do, whenever it may so desire, by cooperation and harmony amongst its members.

Such a meeting as this inspires us with confidence in ourselves and in our undertakings, and must make evident to every individual member, no matter how pessimistic he may be, the strength that flows from systematic and satisfactory organization. This solidification of the medical profession has been the watchword during recent years throughout the United States, under the auspices and guidance of the American Medical Association; and in Maryland the work has been zealously carried on during the terms of office of my two predecessors, and in a very large degree as a direct result of their untiring and intelligent individual work.

Having succeeded two very strenuous Presidents, the present

incumbent, feeling that the duty devolved upon him of following, as far as his weak nature allowed, in their stimulating foot prints, has endeavored to carry out their well defined policy. Finding the State reasonably well organized, with active county societies in almost every county, every effort has been made to complete the organization of those counties still deficient, and to galvanize into strength the few societies that showed loss of vitality. In this matter I have been ably seconded by some of your Councilors, who appreciate, with me, the splendid opportunities now before the profession in Maryland, and who propose to make fullest use of those opportunities. In furtherance of this worthy object, as I regard it, I have already visited, in an official manner, Allegany, Anne Arundel, Baltimore, Caroline, Charles, Dorchester, Frederick and Queen Anne's Counties, in each of which I have met the local county society and have spoken both publicly and privately, at greater or less length, upon the urgent need and manifest advantage of complete organization and harmonious cooperation of the profession throughout the State. These visits have been sources of varying pleasure; while it is always agreeable to meet our brethren, it must be confessed that in some of our county societies there exists room for improvement.

However, the work is young as yet: the seed has been planted too recently to have reached full fruition, we must look to the future for the desired result. Having taken this work in hand there must be no turning back; we must not be satisfied with having a chartered society in every county, but we must not rest until each of these societies shall be an active, living unit of strenuous cooperation forming the grand, solidified, completed Faculty, composed of every physician in Maryland, bound together by the laudable ambition to guard and protect the public and private health of the citizens of this Commonwealth against all attacks from without or within. Until this end is accomplished the work of this Faculty must be fragmentary and preparatory: when it shall have been attained, the need and excellence of our organization must be recognized as a most potent factor working for the direction of society in the way it should go, and aiding the individual to attain personal health and social happiness.

It is to this work that I propose to devote myself during the remaining months of my term of office, relying upon your Councilors as chief aids to my endeavor, but calling at the same time, upon each individual member of every society to give his personal assistance to the work. After all, we must look to the man himself. The county society cannot rise above the capacity of its members; with them, and with each of them, rests the responsibility of success or failure; upon them depends the estimation at which they will be held by the community in which they live and work; as the individual doctor shows himself, so will the public judge of all doctors; to each individual then is this appeal made, that we live in harmony and work together in peace, respecting each other as friends, as brothers of a great and noble family, having high ideals always before us, and laboring ever toward the same goal.

THE EFFORTS TO PROSECUTE UNREGISTERED PRACTITIONERS IN BALTIMORE CITY.

Dr. Herbert Harlan.

It seems to me proper that at this time the Faculty should be informed of what efforts have been made to prosecute unregistered practitioners of Baltimore City, to what extent the prosecution has been successful and where the fault lies for the imperfect success of the efforts referred to.

It will be recalled that in the spring of 1906 a committee of the Baltimore City Medical Society was appointed to work in conjunction with the State Board of Medical Examiners,—difficulty having always been found in successfully prosecuting Baltimore City cases. It may be mentioned that previous to this time the State Board had employed detectives and had worked up what seemed to them and to their Attorney very complete cases against irregular practitioners. These cases were presented by the Grand Jury, but after a few days when there had been time enough for pressure to be brought to bear on the Grand Jury and the State's Attorney's office, chiefly I believe in the way of misrepresentation of facts, the presentments were withdrawn.

The referring of the cases to the State's Attorney's office had been found so universally unsuccessful that a somewhat different procedure was adopted about a year ago. For example, attention had been called to one, Karl Klasius, living on Rayner Ave. Simultaneous letters were written to the State's Attorney, the Marshal of Police and the president of Police Commissioners, and attention was called to the provision of the Law that the Police Commissioners of Baltimore City were to report such cases to the State's Attorney. In this instance the Police investigated, reported, and notified us of having sent their report with a copy of our communication to the State's Attorney's office for his action. This was on May 20th, 1906. On June 13th the following letter was sent:

"June 13th, 1906.

"Albert S. J. Owens, Esq.,
"State's Attorney, Baltimore.

"Dear Sir—On the 21st of May this Board, through its Secretary, Dr. Scott, received a letter from the Police Commissioners in reference to the case of one, Karl Klasius, in which occurs the following sentence: 'I have to say that the case has been investigated and reported, as per copy herewith received. This report, together with copy of your communication to this Department, has been referred to the State's Attorney for his action.'

"May I take the liberty of inquiring as to the present status of this case? Sincerely yours,

(Signed) "Herbert Harlan."

No reply was received to this, and on July 3rd the following was sent:

"July 3rd, 1906.

"Albert S. J. Owens, Esq.,
"State's Attorney, Baltimore.

"Dear Sir—On the 13th of June I wrote to you, making an inquiry about the case of one, Karl Klasius, who has been charged with practicing medicine in this city without being properly registered. The Police Department having previously sent to your office the charges and the evidence in the case.

"I should appreciate the courtesy of at least an acknowledgment of my communication. Very truly yours,

(Signed) "HERBERT HARLAN, Pres.
"Board of Medical Examiners of Md."

To this the following answer was received:

"Baltimore, July 7th, 1906.

"Dr. Herbert Harlan,
President Board of Medical Examiners of Maryland.
Baltimore, Md.

"Dear Sir—Karl Klasius was indicted by the Grand Jury on June 1st, 1906. Under the law he is entitled to a trial by a Jury. We cannot give him a Jury Trial until after the second Monday in September, and when the time arrives for the trial I will give the case my individual attention. Very truly yours,

(Signed) "ALBERT S. J. OWENS,
"The State's Attorney for the City of Baltimore."

Klasius appeared at the June examination and the State's Attorney inquired whether, if he should succeed in passing the examination, would the Board be willing to drop the prosecution. Klasius failed, as he had done several times previously, and during August the State's Attorney called up the president of the Board and asked consent to have the case stetted, as Klasius had left the State. This consent was not given, inasmuch as Klasius had made a number of promises to the Board which he had not kept. Klasius again appeared at the December examination, showing that his removal from the State was not permanent and was only to evade the indictment. It would seem that for some reason the State's Attorney's office is willing that Klasius should have every opportunity to escape punishment. Klasius again failed at the December, 1906, examination, and the docket of the Criminal Court shows that his case was stetted December 12th, on condition of his remaining out of this State.

In May, 1906, the Committee had printed a thousand circulars containing a list of the registered physicians in Baltimore City. Quite a number of copies were left at the Library and a notice was put in the MARYLAND MEDICAL JOURNAL in a most conspicuous

place, asking the physicians of the city to get copies of this list and aid the Committee by notifying them of the name and address of any doctor they might happen to know whose name did not appear on that list. The Librarian informs me that one single copy was asked for. The Committee then went before the Police Commissioners with their Counsel, and requested that one of these lists be given each day policeman in the city, with instructions that the name of any doctor having out a sign which did not appear in the list be reported for further investigation. This resulted in a total of 79 names being reported as not on the list. Most of these men were all right, but it took a great deal of labor to sift them out carefully.

There were some mistakes in the list. There were many cases where physicians had moved to the city from the counties without being transferred on the register. Quite a large number had passed the examination and obtained a license and had, through ignorance, registered at the City Hall instead of at the Circuit Court.

After sorting them all out the Board of Police Commissioners was requested to present to the State's Attorney the names of 13 men. One of these 13 was found to be a resident of Baltimore County and another had left the City. The other 11 were promptly indicted by the Grand Jury in the month of October. In spite of all the efforts of the Committee and their Counsel, even to the extent of appealing to the Judge in charge of the Criminal Court, not one of these cases has as yet been tried. Three have, however, left the city; one has been registered after having shown a proper registration from one of the counties. One passed the December examination and one pleaded guilty and was fined $10.00 and costs, and again tried and again failed at the June examination. Three others were colored and should probably be classed as herb doctors and chiropodists. One was a fortune teller and has been convicted on that charge. Five additional cases were sent to the Grand Jury in March; all five were promptly indicted, but not one of the cases has been brought to trial.

There should also be mentioned the case of one Laurence V. Cohne, who, with Morris H. Edelson, started the Lexington Medical Institute. Edelson put in some money, and, as the venture was a failure, sued Cohne for obtaining money under false pretenses. The magistrate seeing it was a case of practicing medicine without registration, sent for me to be present at the trial. There was evidence from a number of witnesses of examination and treatment by "Professors" Cohne and Edelson, and also that Dr. Charles G. Richardson, 1616 Edmondson avenue, had loaned them his name and his diploma to hang in the office. The cases were sent to the Criminal Court, where Cohne was convicted of assault

in making the examinations without being a registered physician, and he was sentenced to a year in jail in addition to a fine. High legal authority tells me that Richardson was guilty of conspiracy to defraud and could be indicted for that offense, but the most that we have been able to do is to get the State's Attorney to say he would "look into the matter."

The latest statement from the State's Attorney's office is to the effect that the indictments as originally drawn were defective and all the cases will again have to go to the Grand Jury. Two Grand Juries having already acted on all of the above cases, the outlook is that all the witnesses, as well as the president of the Board, will have to go before another Grand Jury,—that all the remaining parties will again be indicted and there is a possibility of some of the cases being tried during the coming fall.

In the State at large outside of Baltimore City, less difficulty has been experienced. One man named Watson was convicted in Alleghany County after several trials, was fined $200.00, then took his case to the Court of Appeals. That Court has recently rendered an important decision, upholding the law in every particular.

To summarize, a great deal has been accomplished. Sixteen parties have been indicated, the most important of whom have left the State, one has pleaded guilty and has been fined and has pledged himself to the Court not to again practice without being registered. One was convicted of assault and is now in jail.

The following are now under indictment:

Howard M. Smith (Col.).
Ernest Tanner, 727 Hanover Street.
John E. Taylor, 1427 Orleans Street.
Robert H. Darrah, 121 Jackson Square.
James E. Creevey, 302 and 303 Professional Building; residence, 663 West Franklin Street.
Pasquale Romeo, northeast corner Albemarle and Pratt Streets.
R. Crowley, 420 North High Street.
Wm. W. Abbott.
Lincoln Cromwell (Col.), 811 Ensor Street.
George Gannaway, 15 South Eutaw Street.
Raymond Gault, 410 Park Avenue.
Thomas E. Green (Col.), 730 Vine Street.

It would seem that we have quite sufficient law to cover the cases. It would also seem that there is now a little popular sentiment in favor of the law, and finally it would seem that the present State's Attorney is, to say the least, indifferent to the interests of the general public and the medical profession, certainly so far as enforcing the Medical Practice Act is concerned. It is hoped that the physicians of the city will bear this in mind when the present incumbent of the State's Attorney's office asks future favors at their hands.

ADDRESS.

THE COMMERCIAL DOMINATION OF THERAPEUTICS AND THE MOVEMENT FOR REFORM.

Geo. H. Simmons, M.D.

Chicago.

THE ANNUAL ORATION BEFORE THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND. APRIL 24, 1907.

PROPRIETARY MEDICINE A RECENT DEVELOPMENT.

The proprietary medicine business as we know it is a development of only a little over a generation. In 1875, Lawrence, of *Medical Brief* fame (?), and his junta of nostrum makers, whose output and that of their offshoots alone have run into the hundreds, were unknown. Thirty years ago the so-called German synthetic chemicals were unheard of as medicines; now, if we include the true and the false, there are thousands of them. Including the typical nostrums, the more or less legitimate proprietary mixtures and the synthetic compounds, the number of proprietary medicines has become so vast that no one is rash enough to attempt to estimate it. A few of these, we may admit, have a distinct value: they represent original work and are worthy of recognition as remedial agents. The vast majority, however, are but the simplest of mixtures or are well-known drugs put out under fanciful names, with no advantage whatever; or are absolute frauds and swindles. Some of these remedies are made by manufacturing pharmaceutical and chemical houses of greater or less repute; the majority by men—or "companies"—who know nothing about medicine, pharmacy or chemistry, and who have gone into the business as they might have gone into any other get-rich-quick enterprise.

This business has been growing more rapidly than ever during recent years, and the statement made here in Baltimore last December that the use of this class of preparations has doubled during the last decade is probably true. But worse than the increase in number is the development in the advertising literature of unblushing falsehood and palpable deception. Conditions in this regard had become so disgraceful—I put this in the past tense because there has been a change since the Council began its work—that there seemed to be no statement too silly, no claim too extravagant, and no falsehood too brazen for use by those who wrote the advertising literature that physicians were asked to read and to believe. It was, therefore, not only the character of the preparations, but the methods of exploitation that had become unbearable and a disgrace to the profession that tolerated it. In brief, this business, the annual profits of which run into the millions, has grown until the use of proprietary medicines by many physicians has almost displaced the use of the individual official drug. It has checked advance in scientific methods of treatment, inhibited intelligent clinical observation and developed an optimism that is unwarranted by facts—an optimism that is more fatal than the most radical thera-

peutic nihilism. But above and worse than all, this commercialized materia medica has blighted our literature by debauching our medical journals and even by tainting our text-books.

And whose is the fault? That the business has developed in this country to such extent, with scarcely a protest on the part of our profession, is a reflection on the common sense and intelligence of the physicians of the United States. We, as well as manufacturers, are at fault. We must assume the blame for becoming such easy dupes to their enterprise and sagacity.

But a change is taking place; a halt has been called, and our profession is awakening to the disgrace of it all. It is about the movement for ridding our profession of this disgrace that I want to speak tonight.

NO PROTECTION IN THE PAST.

We have long suffered from a want of governmental or other supervision over the manufacture of medicines. In no other country has the standard and quality of drugs been left entirely to the manufacturer's honor. From time to time the medical profession has made spasmodic, but weak, efforts to remedy the condition; we find records of this even as early as the beginning of the nineteenth century.

The agitation of those early days resulted in the adoption of a Pharmacopeia, the first issue of which was published in 1820. This standard, by the way, was the work of physicians and was gotten out by them for the guidance of pharmacists, who, however, had nothing to do with its preparation. It is to be regretted that conditions have changed, and that, while the physicians then were the ones interested, for the last 50 years they have left it practically to the pharmacists. While the Pharmacopeia furnishes standards which were accepted by a few as authoritative, it was, after all, but an advisory instrument, and was followed or ignored as suited the manufacturer.

The Pharmacopeia only partially improved matters, and society transactions continued to contain records of criticisms of the prevailing conditions. So it went on until the organization of the American Medical Association. At its first meeting resolutions were adopted indicating that the question was still a vital one. So, again, in 1849, 1850 and every year or two thereafter this subject was discussed. Then, however, the unreliability of drugs was the source of irritation, the proprietary medicine abuse not yet being so much in evidence. In 1879 we first find the association recognizing that incipient evil which has since developed into the modern curse—proprietary medicines. In the Transactions for that year we find the following:

> WHEREAS, Of late years many drugs and combinations of drugs bearing copyright names have been placed on the market and especially introduced to the notice of physicians, and
>
> WHEREAS, Such drugs and combinations of drugs, having copyrighted names, are advocated in the medical journals of the country, be it
>
> *Resolved*, That the use of articles thus protected by copyright and the

promoting of their use by advertising them in medical journals is a distinct violation of Section 4, Article 1, of that portion of the Code of Ethics treating on the duties of physicians to each other and to the profession at large and also of Section 4, Article 1, of that portion of the Code of Ethics treating on the duties of the profession to the public and of the obligations of the public to the profession. (Transactions, vol. xxx, 1879, p. 45.)

From this time on scarcely a year passed that the association did not take action regarding the proprietary-medicine problem, and finally when *The Journal* took the place of the annual Transactions it became, on account of the advertisements, a very practical question. It is worth recording here that there was a time when our profession opposed proprietaryship in medicines; recently, however, this seems to be accepted as a necessary evil.

IMPOSSIBLE TO DEFINE AN "ETHICAL" PROPRIETARY.

It is unnecessary to give in detail the difficulties connected with this question, or to explain how absolutely impossible it has been to decide what is and what is not an ethical[1] proprietary preparation. It certainly has been a trying question for those editors who have honestly striven to have their advertising pages clean and free from fraud. But long ago it was realized that the problem is one that the physician cannot solve by himself. A physician is not supposed to be an authority on pharmacy and chemistry; he is expected to know the physiologic and therapeutic actions of drugs, but not the details of their chemical action or the intricacies of their compounding. This requires a special training and a technical knowledge entirely different from that required for prescribing for the sick.

The pharmaceutical profession bears the same relation to the medical profession that the ordnance department does to the army in the field. The fighting force is not expected to know how to make a rifle, or to have a practical understanding of the manufacture of powder and shot. The men on the firing line know how to use, but not how to make the ammunition. But nevertheless the efficiency of the men at the front is largely dependent on the integrity and honesty of the supplies of the ordnance department.

The trouble has been that the sister professions of medicine and pharmacy have not been co-operating; rather they have been drifting apart.

It was in recognition of this principle that, in 1900, there was published in *The Journal* a series of articles, written by a pharmacist well qualified for the purpose, on "The Relation of Pharmacy to the Medical Profession." Their object was to enlighten the profession regarding the conditions with the purpose of leading up to the suggestion of a remedy. As may be remembered, the remedy suggested was the creation of a body of pharmacists, chemists and pharmacologists who should act for the profession and examine the products on the market, or at least take up the

1. I am well aware that we should not apply the word "ethical" to an inanimate object. I use it because it seems to be necessary.

subject from a practical standpoint. These articles appeared just before the first Atlantic City session, and some of us had a vague idea of proposing such a board to the general meeting, but the psychologic moment did not seem to have arrived and the matter, for the time being, was dropped.

And so time went on, the subject receiving more or less attention in the Section on Pharmacology and Therapeutics at each annual session, till at the Atlantic City session, in 1904, the delegates from Michigan presented to the House of Delegates a preamble and resolutions that had been adopted by their State society, which read as follows:

WHEREAS, An exact knowledge of the composition and properties of substances used in the management of disease is essential to a physician's best success:

WHEREAS, Commercial push, by advertisement and drummers, persuades many physicians (often the very elect), to use and commend drugs, mineral waters, artificial foods, etc., etc., of unknown composition and effects:

WHEREAS, As it is impossible for the individual physician to verify the statements of sales agents, to separate fact from fancy, he often uses substances quite unlike those indicated, to the discredit of himself and his art:

WHEREAS, The American Medical Association was organized to promote the exact knowledge and intelligent practice of its members:

Resolved, That the Board of Trustees, American Medical Association, is hereby requested to provide for the analysis of medicinal substances of unknown composition and undetermined effects, and to publish promptly the results in the Association *Journal*:

Resolved, That the Board of Trustees be requested to appoint a "*Journal* Clearing House Commission," three in number, to serve without salary, with authority to have analyses made in reliable laboratories, by experts of recognized ability, or to equip a suitable laboratory and employ one or more competent experts, at a yearly expense not to exceed five thousand dollars.

THE COUNCIL CREATED.

While these resolutions were not finally acted on, some of us realized that the time had at last arrived for something to be done, and for materializing the idea of a board of control. During the next eight months the general plan was discussed with many physicians and with such chemists and pharmacists as Professors Long, Stieglitz, Puckner, Hallberg and others of Chicago, Professor Cushny of Ann Arbor (now of London), Professor Abel of Johns Hopkins, Dr. Wiley and some of his staff at Washington, Professor Remington, Professor Sadtler, Mr. Wilbert of Philadelphia, Dr. Sollmann of Cleveland, and others. Several meetings were held, at which a few gathered and the general plan and scope of the work was outlined and discussed in all its phases. The matter was presented in detail to the Board of Trustees at its meeting in February, 1905. After discussing the matter fully the trustees authorized the creation of the board, and specified that it be known as the Council on Pharmacy and Chemistry.

Thus it is that the profession now has at its service a group of men who, for this work, possess special training and technical knowledge. Their energies are devoted to the thankless task of winnowing from the chaff of dishonesty the occasional grain of honesty.

The first meeting of the Council was held in Pittsburg, February 11, 1905. This meeting was an interesting one. To me it was not only interesting, but profitable, for my eyes were opened to conditions the very existence of which I had not before realized. Among those present were practical pharmacists, practical chemists, well-trained pharmacologists and physicians. Each group saw things from its own viewpoint, compared notes and exchanged views. As I say, the result was interesting and the revelations both instructive and—humiliating.

The work to be accomplished at this meeting was to lay down certain fundamental principles that should govern the Council in its labors, to devise methods of procedure, etc. The most serious and important phase of the work was the adoption of the rules or principles which should govern the Council in deciding whether or not a preparation should be accepted.

The first thing an intelligent physician does when he is called to treat a patient is to make a diagnosis of the disease, learn its cause, and remove it if possible. On this principle the Council attacked the problem.

RULE 4.—INDIRECT ADVERTISING TO THE PUBLIC.

It was recognized at the outset that the first objection to proprietary medicines is that the prescribing of such preparations is apt to lead to self-medication by the public and the manifest evils which this entails. The fact that physicians themselves are responsible for at least some of the "patent medicine" business is well known to every pharmacist and to every physician who has given the matter thought. A physician writes a prescription for a proprietary preparation that has a catchy, easily-remembered name, and thinks that the matter ends there, but the manufacturer knows better; the patient gets the medicine, and with it all kinds of information regarding its virtures. The physician may instruct that the label, circulars, etc., be removed, but in many cases this is not done, and usually no such instruction is given. The patient learns from the printed matter that that particular medicine is good not only for the diseases for which the doctor prescribed it, but for every other real or imaginary ailment with which he may be afflicted. In this way there has been introduced to the public a host of "patent medicines" without a cent of cost for advertising, except that to physicians.

The full directions for use which accompany these medicines are, in part at least, responsible for counter-prescribing by druggists. There is a peculiar fascination—at least to the average pharmaceutical tyro—in posing as a prescriber, exemplifying the old saying: "A little knowledge is a dangerous thing." The "proprietary" nostrum vendors give him the "little knowledge," sufficient, that is, to sell their preparations. He soon becomes familiar with the reading matter and he is impressed, or pretends to be, with the wonderful properties of the preparation as described in the circulars. He adds his recommendation to those of the doctors whose testimonials he shows to the customers on the other side of the counter.

This indirect advertising to the public was the first evil to be overcome, and the first principle adopted by the Council is incorporated in what is now known as Rule 4. It is as follows:

> No article will be admitted whose label, package or circular accompanying the package contains the names of diseases in the treatment of which the article is indicated. The therapeutic indications, properties and doses may be stated. (This rule does not apply to literature distributed solely to physicians, to advertising in medical journals, or to vaccines and antitoxins.)

It is this rule that has met with opposition from those who are not satisfied with the doctors' patronage, but want that of the public also. It is this rule that is of most importance to the physician, for its enforcement will check one of the worst evils connected with the proprietary medicine business—that which makes the doctor an advertising medium to the public.

Certain manufacturers oppose it because, they say, the doctor needs the information and the instruction that is given on the labels and in the circulars. The reply is that it is not necessary for the doctor to go to the drug store to learn what a remedy is good for, even though he is one of those who depend on the manufacturer for his knowledge. If a doctor dispenses his own medicine and has to depend on the manufacturer for information regarding its use, let that information be given in the literature not attached to the package.

Medicines manufactured solely for physicians' use, such as the official preparations and those of the National Formulary, are not accompanied with circulars or advertising matter and there is no valid reason why proprietary medicines should be. If the manufacturer wants to enlighten the doctor regarding the value of his preparation, let him advertise in the medical journals; let him send the circulars, or his detail man, to the doctor direct; in any event, there are many ways of letting the doctor know in what diseases the medicine is indicated without putting it on the bottle. It will be noticed that Rule 4 permits therapeutic properties and doses to be given in the literature accompanying the package. Many believe, and with good reason, I think, that the Council has been too liberal in this, that no such information is necessary in that connection.

It has become a recognized fact in the "patent-medicine" field that the easiest and cheapest way of reaching the public is by advertising through the doctor. Let me quote a paragraph that appeared in *Printers' Ink*, an advertising journal, some two or three years ago. The words are those of a "patent medicine" man, and, of course, were not directed to physicians:

> But the patent medicine of the future is the one that will be advertised only to doctors. Some of the most profitable remedies of the present time are of this class. They are called proprietary remedies. The general public never hears of them through the daily press. All their publicity is secured through the medical press, by means of the manufacturer's literature, sometimes gotten out in the shape of a medical journal, and through samples to doctors. For one physician capable of prescribing the precise medicinal agents needed by each individual patient there are at least five who prescribe

these proprietaries. They are the chief standby of the country practitioner. * * * Three-fourths of all the prescriptions received are for these proprietary remedies, and the pharmacist simply opens the package and writes a label, "A teaspoonful three times a day before meals." * * * The original bottle is given to the patient. He sees that the remedy does him good, and when he feels a trifle run down again he goes to a drug store and buys another bottle, not troubling the doctor. He meets a friend on the street who is not looking well. "I know exactly how you feel," he says. "Now, just go and buy a bottle of ——. Best thing in the world. My doctor prescribed it for me, so it isn't a 'patent medicine.'" In this way the names of the remedies advertised only to physicians get abroad to the general public. * * * The proprietary medicine of the future, though, will be advertised through these channels. The medical papers will reap the harvest, and the physician himself, always so loud in the denunciation of "patent medicines," will be the most important medium of advertising at the command of the proprietary manufacturer. In fact, he is that today.

Have you ever seen an arraignment of this evil by its enemies which equals this cynical statement of its friends?

Is it necessary to say more on this point? In fact, can anything more be said? What I have just quoted should be read by every nostrum-prescribing doctor in the country, and, having read it, he should go to some quiet corner and kneel down and pray the Lord to give him a little common sense.

Now, while I am quoting, let me quote something else. This is from a book written by Mr. George P. Rowell, entitled "Forty Years an Advertising Agent." Mr. Rowell, as some of you may know, dabbled somewhat in the "patent medicine" business himself. He is the one who created Ripans Tabules. In this book, by the way, he tells how he came to put this preparation on the market. In the chapter from which I shall quote he described the "patent medicine" business in an interesting way, and tells of the fortunes that have been made and also lost. He has this to say about an "ethical" proprietary that some of you may have heard about:

We had a successful advertiser in Halifax, N. S., who sold a medicine known as Fellows' Hypophosphites, that proved so good that some shrewd business men in the medicine trade who knew about it, bought the trademark, incorporated a company with a capital of $100,000, retained the original owner as manager, stopped all advertising except in medical journals, and thereafter pushed the sale only through the medical profession. I had information at one time of a young man who was heir to an uncle, recently deceased, and had come into possession of a certificate of stock of this company, of the face value of $6000, and made up his mind that, shrewd as the old gentleman was, he had, without doubt, acquired trash in this instance; and I heard further, that the young man began to think better of the doubtful asset, when one day a dividend check came; and when, at the end of the year, he realized that within the twelvemonth that $6000 certificate had brought him $9000 in dividends, he began to revise his estimate of his deceased uncle's prescience in making investments.

As a "patent medicine" it was not a success, but as an "ethical proprietary" it has been proving a gold mine. So, since that time this medicine has not been advertised except to doctors through medical journals, has it? Look at the wrapper around the bottle, read the label on the bottle, notice the name blown into the bottle, and then will you doubt the statement of the average druggist when

he says that nine-tenths of Fellows' Hypophosphites is sold over the counter direct to the public and that the doctors are responsible? What better method of advertising? And how easy! Newspaper advertising is expensive! It is cheaper to use the doctor!

The principle incorporated in Rule 4 is one of the most important principles adopted by the Council. It threw out at once three-fourths of the proprietary medicines on the market. For is it to be supposed that the promoters of Fellows' Hypophosphites, Gray's Glycerine Tonic, Glycothymoline, Antikamnia, Antiphlogistine, Phenalgin, Santal Midy, and most of the self-styled "ethical" proprietaries would conform to Rule 4? From their standpoint the proposal is absurd.

RULE 1.—NON-SECRECY.

Everybody—that is, *nearly* everybody—agrees that a physician should know what he prescribes. Some intimate that he has no moral right to give a medicine unless he knows what he is giving. A few emphatically express the view that it should be made a criminal offense for a physician to give a patient a medicine when he does not know exactly what it contains. I must acknowledge that I am much tempted to side with the latter. In any event, after agreeing on Rule 4, the Council again went back to general principles, and adopted the following, which is known as Rule 1:

> No article shall be admitted unless its active medicinal ingredients and the amounts of such ingredients in a given quantity of the article be furnished for publication. The general composition of the vehicle, its alcoholic percentage, if any, and the identity of other preservatives, if present, must be furnished.

There was little discussion when this rule was under consideration. Even the verbiage was soon agreed to. It is so palpably consistent, so absolutely fair and just that one would have imagined that it would receive universal approval. But do you remember the protests of certain medical journals when the first announcement was made and these rules published? It was simply outrageous, we were told, that enterprising firms which had spent money and time in getting up a fine combination should be asked to state what the combination contained. One New York medical journal even went so far as to send a circular-letter to the manufacturers offering them space in its columns for an expression of their views in regard to the outrageous attempt that was about to be made to injure their business. Certainly, this attack on vested interests was scandalous, and it was a good thing that the proprietary people were so well guarded by a journal that is published in the interests of physicians.

But the proprietary gentlemen were too wise—they did not accept the offer, since nothing appeared from them. In fact, the majority of the nostrum men have said that they always have been, still are, and always will be willing to tell physicians what their preparations contain. They agree that physicians should know what they are prescribing, that it is very necessary they should know. It would be wrong, indeed, if physicians should prescribe

without knowing what they are prescribing, say these gentlemen. Surely! And the more quackish the preparation and the "company" that exploits it, the more willing they are to give a formula. Mind you, I say "a" formula.

When, some 12 years ago, the Board of Trustees ordered that no proprietary should be advertised in *The Journal*, unless the advertisement was accompanied with a formula sufficiently often to let the reader know of what the preparation consisted, they imagined that they had done away with the evil—secrecy. And this has been the cry since—publish the formula and the preparation becomes ethical. It did not seem to dawn on those who were especially interested in this subject that connected with the exploitation of the proprietaries were most extravagant claims as to their therapeutic value, and that those who would make misstatements regarding the therapeutic action of their preparations would not hesitate to stretch the truth when they made statements as to the composition. The formula was the thing. If the formula was forthcoming, the preparation was ethical. But it has developed that the more fakish the nostrum the more willingly was the formula furnished. So it is not strange that there were admitted to the advertising pages of *The Journal* such fakes as Ammonol, Phenalgin, Labordine, Campho-Phenique, Salacetin, Hagee's Cordial of Cod Liver Oil Compound and Tyree's Antiseptic Powder.

The idea that the publication of a formula will make a preparation ethical has been harped on and emphasized until many believe it. Now the fact is most of the proprietary mixtures are simple combinations of well-known drugs that any pharmacist, or even an average physician, could compound if the active ingredients were known. Therefore, would not the makers of such preparations be very foolish to give the correct formula even as to the active ingredients? Surely they would be, and the average nostrum maker is not a fool.

I presume it is unnecessary to say that the Council is not satisfied with "a" formula, but demands "the" formula.

RULE 6.—EXTRAVAGANT THERAPEUTIC CLAIMS.

The man who has something to sell naturally wants to impress the prospective buyer with all its good qualities. This is business—honorable business. Incidentally, in the business world it is expected that the seller, while emphasizing all the good qualities, will tell the truth. An exception to this rule may be made to the horse-trader. He, proverbially at least, is expected to overstep the bounds of truth in his comments on the quality of his animal. But the other gentleman knows this and discounts his statements accordingly. He examines the animal, or if he thinks himself deficient in the necessary knowledge to pass judgment on the value of a piece of horse flesh he gets the advice of a friend who has this knowledge.

I admit it is rather far-fetched to compare horse-trading with a proprietary medicine business, but there does seem to be a simi-

larity—and also a difference. The seller in both instances is given to a slight exaggeration as to what the respective articles will do in their respective spheres of action, but in one case the buyer, at lease as a rule, takes it for granted that the seller is likely to stretch the truth. At least, he is healthily skeptical about the matter and does not believe all that the horse-trader says. In the other case the buyer, to borrow a simile from another department of life's activities, is quite likely to swallow not only the bait, but the tackle also. Perhaps he is not so much to blame after all. It is a little difficult for honest physicians to realize that others traffic in human life.

The claims in the advertisements of "patent medicines" are so absurdly extravagant that a "patent medicine" advertisement has become synonymous with mendacity. In too many instances this also applies to advertisements of so-called "ethical proprietaries." There is no limit to the license allowed those who write the advertising matter that is to influence physicians to use the products advertised.

To repeat again, there seems to be something connected with the "patent" and proprietary medicine business that demoralizes. An honest, conservative statement about the merits of a proprietary preparation is as rare as are sweet violets in Iceland. As regards the large majority this is not to be wondered at. To tell the truth about either their composition or their therapeutic value would be to stop their sale. But there are proprietary medicines that have merit and that would be used even ifthe simple, unvarnished truth were told about them, but the habit of exaggeration crops out in the advertising of even these.

This was one of the evils recognized and so Rule 6 was adopted, which says:

> No article will be admitted or retained of which the manufacturer or his agents make unwarranted, exaggerated or misleading statements as to therapeutic value.

Of course, the principle underlying this rule is so elemental that one might think that it would meet with no opposition when put into practical application. Yet its actual enforcement has caused much trouble, in spite of the fact that there has been a liberal interpretation of the literature. The diversity of opinion and varied experience in the use of therapeutic agents has been recognized and the Council has admitted every reasonable claim, everything short of absolute misstatement and palpably false pretension.

OTHER RULES.

The three rules above considered meet the most objectionable features of proprietaryship in medicine. Indirect advertising to the public through the physician, secrecy in composition and false therapeutic claims. The enforcement of these three rules would do away with the main evils connected with the proprietary business, and incidentally would wipe out a goodly number of the products. The other seven rules, while important, some of them

being necessary for the enforcement of the three already referred to, need but a brief referenc here:

Rule 2 is:

No chemical compound will be admitted unless sufficient information be furnished regarding tests for identity, purity and strength, the rational formula or the structural formula, if known.

There are many preparations on the market, both domestic and imported, that are claimed to be definite chemical compounds, but which are not. This rule guards against such, as well as against adulteration, etc. No objection has been made to this rule.

Rule 3 says:

No article that is advertised to the public will be admitted; but this rule will not apply to disinfectants and food preparations, except when advertised in an objectionable manner.

This rule, of course, refers to open, direct advertising to the public, in the public press, etc. It is not necessary to defend this rule, before physicians at least. It provides for conditions entirely different from that covered in Rule 4.

Rule 5 is:

No article will be admitted or retained concerning which the manufacturer, or his agents, make false or misleading statements as to geographical source, raw material from which made, or method of collection or preparation.

The proviso in this rule is incorporated in the national Food and Drugs Act and needs no comment.

Rule 7 says:

Labels on articles containing "poisonous" or "potent" substances must show the amount of each of such ingredients in a given quantity of the product. A list of such substances will be prepared.

This rule is not really necessary, since the passage of the national Food and Drugs Act covers many of the substances referred to.

Rule 8 is as follows:

If the trade name of an article is not sufficiently descriptive of its chemical composition or pharmaceutical character, or is, for any other reason, objectionable, the Council reserves the right to include with the trade name a descriptive title in the book. Articles bearing objectionably suggestive names will be refused consideration.

The last sentence was not in the original draft: experience showed the necessity of such a rule. I doubt if anyone will think this an unwise precaution, when we run across such names as: Gonosan, Gonorin, Gonoral and Gonol, names certainly suggestive enough even to the most ignorant layman, and remembered without difficulty by those who wanted to tell their fellow-sufferers what they were taking. Genitone, Vaginol, Oöphorin, Virilin, Rheumasan, Bronchitin, Pneumin, etc., are others. I am not quoting fanciful names from the "patent medicine" list; they are all advertised to physicians as scientific preparations.

Rules 9 and 10 merely require information regarding the copyrighted name, and, if the article is patented, the number and date of the patent. They are as follows:

Rule 9:

If the name of an article is registered, or the label copyrighted, the date

of registration and a copy of the protected label should be furnished the Council. In case of registration in foreign countries, the name under which the article is registered should be supplied.

Rule 10 states:

If the article is patented—either process or product—the number and date of such patent or patents should be furnished.

These rules were adopted in a tentative way at the Pittsburg meeting. In the following September the Council met at Cleveland, and to that meeting were invited representatives of the various branches of manufacturing and importing interests for consultation and suggestion. The various rules were discussed and only slight modifications were made. The only rule that was objected to by the manufacturers' representatives was Rule 4, but all who took part in the discussion acknowledged that the principle underlying the rule was a just one and would work no hardship on those manufacturers who were catering to physicians only.

At the Pittsburg meeting it was decided that when it was necessary for the manufacturer to change the labels, circulars and other advertising matter, he should be given ample time in which to comply so that he might not experience undue expense or hardship in meeting the requirement. At the Cleveland meeting this time was extended definitely until July, 1906. Thus, previous to July, 1906, the Council accepted preparations even though the labels, literature, etc., might not have been in accord with the rules, on the promise of the manufacturer to make the necessary modifications in a reasonable time. However, since July 1, 1906, the literature, labels, etc., must be correct before the preparation is accepted.

I have discussed these rules at length that you may know what they are and what they mean. Together they give what has never been given before, a definition of the term, "an 'ethical' proprietary medicine." Is it satisfactory? Together they make the standard by which the Council judges proprietary medicines. Is the standard too high?

PROCEDURE.

As the members of the Council are scattered, meetings, except at rare intervals, are impracticable. The method of procedure, however, is simple, communication between the members being through a bulletin prepared and sent to each member by the secretary every Thursday. In this bulletin are arranged systematically the reports, motions, comments, etc., the matter being indexed so that ready reference to all past work is at hand for each member.

The Council is divided into three definite divisions—chemistry, pharmacy and pharmacology. Articles are assigned to a sub-committee usually consisting of but one member for preliminary report. This sub-committee consults with other members, with outsiders, and, if thought advisable, makes or has made chemical analyses or physiologic examinations. If the sub-committee desires to communicate with the manufacturer, the correspondence is conducted through the secretary of the Council, the identity of the sub-committee not being divulged.

When ready the report is placed in the Bulletin, together with such correspondence or other matter that the sub-committee may think necessary for the guidance of the members in arriving at a conclusion. The report may be preliminary or final. If preliminary, suggestions and advice are asked. If final, the article is recommended for either Class A, B, C or D, and reasons given for the recommendation. When the final report is made, it is before the whole Council for action. If the article is put in Class A, it means acceptance; if in Class B, more definite information regarding the composition is wanted; if in Class C, certain modifications in the literature are required, and, if in Class D, it means refusal of recognition.

The assignment of an article to Class A or Class D is not necessarily final. If an article which has been voted to Class A is later found to conflict with the rules, the action of the Council may be reconsidered. Similarly, an article voted to Class D may again be taken up and finally accepted if it is found that it has been made to conform with the rules.

Many manufacturers, believing that the publication of certain information in regard to their products would detract from their value, have often volunteered to furnish information for the private use of the Council. The Council, however, does not receive trade secrets, but insists that all information it receives may be published at its discretion. The Council desires information for the profession, and not for itself alone.

CHEMICAL EXAMINATION NOT ALWAYS MADE.

It is needless to say that the Council does not make chemical examinations of every remedy. Such a task is manifestly impossible. If the authors of text-books on physiology, on anatomy or on practice, were to verify every statement they made, such works could not be completed in a lifetime. Instead, the authors, by virtue of their general knowledge of the subjects on which they write, select the truths as they see them. These, finally presented in the form of a text-book, are again accepted as truths by students, because they believe that the author was competent to select from the mass of literature at his command those statements which were most probably true. In the same way the Council has attempted to prove or disprove statements which seemed questionable, while it has accepted those which, from its general knowledge, were believed to be true. In this matter it is needless to say that the Council has been inclined to accept statements made by firms or persons known to be reliable and responsible, while it has been inclined to examine more closely the statements made by irresponsible parties, or by those who seemed to be inclined to exaggerate.

FORMULA NOT ALWAYS RELIABLE—EXAMPLE.

At first it was supposed that the statements of all the legitimate manufacturing firms could be taken without question. This supposition, however, was not well founded, and it is here that some of us have been sadly disappointed. We supposed that it was only

the pseudo-chemical concerns, those which are not in the legitimate manufacturing pharmaceutical business, who were the offenders, but in this we were mistaken. Even the regular manufacturing concerns have among their specialties preparations that are as fraudulent as are any put up by the typical nostrum vendors. One old-established house for years has had on the market a surgical dusting powder, which it advertised as a definite synthetic chemical compound, the result of great scientific research. The published formula was worded to mystify, and extravagant claims were made for the product. Our chemists showed that this wonderful preparation was a mixture containing approximately 70 per cent. of boric acid, 20 per cent. of acetanilid, with a little thymol, bismuth, cinchonin and salol. This is by no means an isolated case, but fortunately for one's faith in business integrity there are at least some firms that to physicians as scientific preparations.

COUNCIL DOES NOT RECOMMEND USE OF ARTICLES ACCEPTED.

The acceptance of an article does not mean that the Council recommends it; this is emphasized by printing the following disclaimer with every publication of accepted articles:

> The Council desires physicians to understand that the acceptance of an article does not necessarily mean a recommendation, but that so far as known it complies with the rules adopted by the Council.

At the inception of the work, it was decided to adopt an extremely liberal policy and to accept a preparation that met the requirements, even though it might not be considered of any great therapeutic value, or as representing anything new or important from a chemical or pharmaceutical point of view. Later, when the Council obtains the fuller co-operation of the profession, a higher standard may be adopted for acceptance. In sifting the wheat from the chaff it is sometimes advisable to have a coarse enough sieve to let a little chaff go through, but later on it may be desired to have the pure wheat without any chaff; then the sieve must have a finer screen.

It is presumed that physicians will think for themselves and use their own judgment regarding the therapeutic value of the preparations accepted.

THE BOOK—NEW AND NON-OFFICIAL REMEDIES.

We have been speaking of "accepting" or "approving" preparations. Accepting for what? Approving for what? Not for the advertising pages of *The Journal,* as some have seemed to imagine. It would be absurd to go to the trouble and expense for such a purpose. In a sense, the Council is compiling a book, and acceptance of an article means that it is accepted for inclusion in this book. It will be known as "New and Non-Official Remedies," and will represent the actual tangible evidence, or result, of the Council's work. It will contain a description of those proprietaries which have been approved, together with such non-proprietary drugs as have come into more general use and are not as yet in the Pharmacopeia. Is it necessary to present arguments to prove that such a book is needed? Heretofore there has been no book, in

this country at least, that a physician could turn to for information regarding non-official preparations. Every day a physician in active practice who reads sees mentioned in his journals medicinal preparations about which he knows nothing. But he wants to know. Where shall he look? They are not mentioned in the Pharmacopeia, in the National Formulary, nor in but few, if in any, of the standard text-books on materia medica. Heretofore he has had only one satisfactory source of information, if it is a proprietary—the manufacturer. And the information he will receive from him will most likely be voluminous, but too partial for unquestioning acceptance. Why not make it unnecessary for such an inquirer to depend entirely on biased information?

This book will tell him what the preparation is, what is claimed for it, the dose, where it can be obtained, and whether patented or trademarked. It will give him the most favorable information consistent with truth, quoting even the claims of the manufacturer, if they are not too optimistic. But it will tell him what will not be found in the literature sent him by the manufacturer—it will inform him if it is liable to have untoward effects, etc. It will, in short, supply him with information that is uninfluenced by commercialism.

It will be supplementary to the Pharmacopeia, and will contain preparations that later will become official, as, for instance, the various patented products which, because they are proprietaries, are not usually admissible to the Pharmacopeia. The last revision of the Pharmacopeia contained preparations that, while in general use by physicians at the time, did not appear in the former edition. In 1893, for instance, phenacetin was in general use, but it did not appear in the Pharmacopeia issued in that year. If this preparation, which is now official as acetphenetidin, is a good thing today, it was then. There are a number of such preparations already accepted that will probably be in the next Pharmacopeia.

BOOK NOT LIMITED TO PROPRIETARY ARTICLES.

At the beginning it was intended to include in the book only proprietary articles, but time and experience have shown the need of including more than these. New drugs are continually being added to our therapeutic armamentarium that are not in the Pharmacopeia. For instance, a little while ago phenolphthalein, long in use in laboratories, etc., as an indicator, was discovered to have purgative effects, and clinical use seems to demonstrate that it may have certain advantages over other aperients. In fact, it is already on the market under various proprietary names, as purgen, purgen konfect, purgatol, purgotin, laxirconfect, laxine, el zernac, etc. The Council has decided to include this in the book. Thus physicians will be able to learn what phenolphthalein is at the outset and will not be deceived for years into using it under various fanciful names and at many times its cost. But, above all, they will not be misled by the extravagant claims of commercial interests.

Hexamethylene tetramine had been known before its value as a urinary antiseptic was discovered; then it was put on the market

under various trademarked names. At the present time the Council would undoubtedly accept this for the book, with a description, and we would not be bothered with a dozen or more different names for the same article. Incidentally, I hoped a less cumbersome name would have been given the preparation than was adopted by the Committee of Revision of the Pharmacopeia. Four trade names for hexamethylenamin already have been accepted, but this is done not to encourage many names for the same thing, but to furnish information. Thus a reference to the book will disclose that Urotropin, Formin, Methaform and Uritone are different manufacturers' names for hexamethylenamin.

The permanent addition to our materia medica of really meritorious articles has been slow, extremely slow; but the elimination of those without merit has been still slower. And, what is of more importance, this elimination has been achieved at the loss not only of money, but possibly even of human lives. The indiscriminate and unscientific drug experimentation that has been carried on by physicians at the behest of commercial interests and without any knowledge except that furnished by such interests is not creditable. It is hoped that this book will check this, to some extent at least.

BOOK WILL BE AN ANNUAL.

The idea is that this book will be issued as an annual, each revision to include the addition of new drugs and proprietary articles that are deemed worthy of admission; those that for good and sufficient reasons should be omitted will be left out. The descriptive matter will also be modified as may be found necessary from the developments of the year. Manufacturers are slow to call attention to untoward results. It will be the function of the revisers of this annual to incorporate both the favorable and the unfavorable.

Personally, as one who has had experience in general practice, I know that it will be of immense value. Heretofore there has been no way for the conscientious practitioner, the medical writer or the editor to differentiate the true from the false. For these the book, "New and Non-Official Remedies," will furnish a reliable guide.

While I have spoken of this book as of the future, the fact is the first or preliminary edition was issued some six or eight weeks ago. This, however, is simply a reprint of the articles as they appeared in *The Journal* and is issued for two purposes: To invite criticisms and suggestions, and, what is more important, to furnish even now a book of reference for those who want to support the Council in this movement by using only such preparations as have been approved. Another similar edition will be issued shortly, slightly modified, with an index and more information than appears in the first reprint; and, of course, it will include the articles that have been accepted since the first edition was printed. It is probable that two or three editions of this preliminary report may be issued before the official book is published.

(*To be continued in November.*)

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JOHN S. FULTON, M.D., *Editor*

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BALTIMORE, OCTOBER, 1907

TYPHOID AND TIN CUPS.

WITH the crescent promise of 200 deaths from typhoid fever, popular discussion in Baltimore drifted from milk and water to tin cups. The Health Department has sounded and resounded its annual warning, "Boil the water." In the public schools raw water is supplied, and the common drinking cup is a fixture. Newspaper men asked members of the Board of Education whether, in view of the Health Department's published advice, the school drinking water would be boiled, and this led to a discussion of coolers, buckets and cups. The Department of Education gave many reasons —one good one—for not boiling the water. On good authority it was shown that the tin cup is not a potent instrument of infection so far as typhoid is concerned. Typhoid bacillus does not pass from lip to lip by way of the promiscuous cup; buckets and cooler are not likely to add to the typhoid possibilities of raw water; the bacillus, if present, is not likely to increase while the water is stored. These and other facts seem to indicate that promiscuity in school is no more dangerous than promiscuity at home, so far as typhoid is concerned. It might be so if children drank as animals do, without the aid of hands. Hands make all the difference in the world between home promiscuity and school promiscuity. A boy's hand is of constant, varied and often mischievous utility.

The story of a recess will shed some light on the possibilities of swapping infection at school. Recess is divided into two unequal periods. The first must be made as short and the second as long as possible. Before recreation one must urinate and have a drink. The 12 speediest boys line up at the urinal trough and 12 less speedy line up behind them. The advantage of getting there first is nothing to boast of, for the 12 behind do not wait, nor the third 12. All 36 use their hands in the act of urinating and afterwards make a dash for the water supply. The tin cups are not far away, distant about five seconds, chained near a spigot just outside the toilet-room, or possibly in the toilet-room. A surprising number of boys can make the trip from outfall to intake without sacrificing an appreciable part of their recess, and this scramble is characterized by every variety of misdeal possible to boys' hands in haste or in mischief.

It is hard to doubt that this indescribable promiscuity sometimes lends additional pollution both to the cups and the water, or that the typhoid bacillus is not sometimes transferred from one boy's bladder to another boy's stomach during the rush moments of recess. This situation suits the typhoid bacillus admirably, for this bacillus is accustomed to live from hand to mouth.

This argument has been overlooked by those who give reasons for not boiling the water. That is a pity, for only one of the reasons so far offered in defense of the raw water and the common drinking cup is stronger than this one. Coming from a medical observer this argument is merely suggestive; coming from the Department of Education it would carry conviction.

TYPHOID AND THE PRICE OF FUEL.

According to the public prints the Board of Education gave several reasons for disregarding the Health Department's advice about boiling the water. One of these reasons is good, as we have said. The Board of Education cannot afford to boil the water. If a special appropriation were made for the purpose, and if, by boiling the water, all the water-borne diseases contracted in the public schools should be prevented, the investment would be a losing one. For a child is not worth much to the city. Between the loss of a child and the expenditure of any sum above a few dollars, the city must choose to save the dollars and sacrifice the child. Coal will never be cheap enough nor children dear enough to justify an appropriation of public funds to furnish children boiled drinking water. To interrogate the School Board about the drinking water is more unreasonable than it would be to ask the Water Board whether the Gunpowder river is to be boiled, and if not, why not. The Health Department's injunction indicates that part of the price of safety which the people must pay out of their private purses. If the whole population of the city should attempt to follow the departmental injunction, the strain on private resources would be more ruinous than any typhoid epidemic ever recorded. A population of half a million could not adjust itself in many years to such a necessity. Nevertheless, thousands, probably tens of thousands, of Baltimoreans do pay annually the price of a safer drinking water. The bottled waters must reach thousands of citizens or the sales would not be profitable. Private filters are by no means uncommon in Baltimore. Other thousands drink boiled water year in and year out. If it were possible to ascertain the number of consumers of bottled waters, and of filtered waters, and of boiled water, it would not be difficult to estimate the tax now borne by private citizens for the sake of a safer water supply. Undoubtedly it is a large sum, so large that a proposition to purify the whole water supply at a proportionate cost would make a stupefying show in figures. The thousands who regard the Health Department's injunction, either by boiling or filtering the city water, or by buying bottled water, pay from 2 cents to 15 cents a gallon for their drinking water. There are more than 10,000

citizens in this class, certainly. If 50,000 citizens regularly pay the price of safer drinking water, their total annual expenditure would probably finance the purification of the whole supply, giving to every person 100 gallons a day of safe water. To purify the whole water supply should not cost more than $6.50 per 1,000,000 gallons, and the per capita cost per year for Baltimore should be about 20 cents.

TYPHOID FEVER IN POLITICS.

Up to this time the illness of Judge Austin L. Crothers has not been followed by any arrest. If the police have any clue to the responsible persons, their suspicions have not become public. The public mind has been very generally moved to sympathy, but is not at all inflamed by this covert and dangerous assault on the Democratic candidate for the Governorship. This calmness in the face of a situation threatening consequences of unusual and far-reaching gravity, if it be enlightened calmness, is perhaps admirable. For typhoid fever is, after all, no more preventable than murder, and a Grand Jury should preserve equanimity just as scrupulously, whether the victim is a very distinguished public man or the least among six or eight thousand other persons similarly attacked. There is but one reason for greater watchfulness in the case of a man who has become conspicuous in public affairs, namely, that such a man incurs greater risk of gun play.

In the matter of typhoid Judge Crothers should have had a slight advantage over his opponent, for Mr. Gaither is somewhat younger. Judge Crothers sacrificed this slight advantage by beginning his campaign several weeks earlier. The early candidate gets his bacillus first. It is incumbent on Judge Crothers' campaign attendants to search backwards for the time, place and agent of his misfortune. Starting from the seventh day before the notification, meeting and counting back to the twenty-sixth day, will give the time limits of the inquiry. In that period every person who gave Judge Crothers a drink of water should be held under suspicion.

For Mr. Gaither's campaign attendants the opposite course is recommended. From now forward to the end of the campaign every person who gives Mr. Gaither a drink of water should be registered in a catalogue of suspicion. If Mr. Gaither is susceptible to typhoid, his chances in a similar campaign should be two and a half times greater than those of Judge Crothers. For Mr. Gaither is a resident of Baltimore city, where the average man exhausts but 10 chances against 25 exhausted by the average resident of a lesser town. The hopeful phase of Mr. Gaither's outlook lies in nature's rigorous economy. If typhoid fever can make effective entry into politics by attacking one of two chief candidates, more than one will not be attacked. If 600 deaths in a year will cause the people of Maryland to line up against typhoid fever, typhoid fever will not kill another 600 in another year. Will typhoid fever be a moving question at Annapolis this winter? Who will move against it? The friends of Judge Crothers, or the friends of Mr. Gaither, or the friends of the 6000 who were also attacked?

Medical Items.

BALTIMORE.

Dr. Doty, health officer of the port, is taking special precautions with vessels arriving from Russia owing to reports of the presence of Asiatic cholera in the vicinity of Libau. The Russian liner Lituania, which came in on September 13 from Libau and Rotterdam, was detained at quarantine for 24 hours and a thorough inspection made of all her passengers and crew.

Baltimore has a genuine epidemic of typhoid fever. The incidence of the disease in physicians and politicians is unusual. So far as the individuals attacked are concerned this distinction is probably unmerited, but if physicians and politicians should suffer a little more than their indicated share of the disease the discrimination would not be unjust and might prove salutary. The city is not at all warmed up to the situation. Of course, the epidemic will pass; it is now passing. All conditions are normal except the figures.

The Baltimore health report for the week ending September 21 showed that 103 cases of typhoid fever had developed in the city during the past seven days. This was an increase of 52 cases over the corresponding week of last year. There were 14 deaths from the disease. The week's health report showed that causes of death other than typhoid were: Consumption, 25; cancer, 15; organic heart diseases, 6; penumonia, 4; bronchitis, 3; diarrhea, under two years of age, 34; Bright's disease, 11; congenital debility, 9; old age, 3, and accidents, etc., 11. The total number of deaths was 202, as compared with 212 for the corresponding week of last year, 196 in 1905, and 181 in 1904. The annual death-rate in 1000 of population was: Whole, 17.30; white, 14.67; colored, 31.20. The nativity of those who died was: United States, 105; foreign, 34; colored, 54; unknown, 9.

GENERAL.

The following account of an outbreak of typhoid fever in the State Hospital at Trenton, N. J., is furnished by Dr. Henry Mitchell, secretary of the State Board of Health:

Twenty-eight days have now elapsed since a new case of typhoid fever has been reported from the State Hospital, Trenton, and we may therefore conclude that the epidemic which recently prevailed in that institution has finally ceased.

To briefly review the important facts having relation to this outbreak, it may be stated that the first case occurred April 8, 1907, in the person of an inmate of the hospital, located in the west wing of the building, who probably contracted the disease in the city of Trenton. Subsequent cases occurred in the same wing, and up to August 13 80 cases had appeared in the hospital, with 16 deaths. All of these cases were located in the main building of the institution, and no cases occurred in the annex, notwithstanding that more than 400 of the inmates of the institution are cared for in that building. Twenty-three employes and other residents in dwellings on the hospital premises were affected with the disease. Investigations concerning the food supply, including milk and water, were negative, except that colon bacilli were found in the water of the spring from which a portion of the water provided for the hospital premises was obtained. Suspicion was at first directed to the water of this spring as the medium through which the infection was spread, but in the light of later developments it now appears improbable that the spring water had any influence whatever in conveying the infection, and we are led to the final conclusion that the disease was transmitted directly from patient to patient and through the agency of utensils and food infected within the building.

The conclusion is justified for the following reasons:

1. The disease first appeared in the west wing of the main building and spread to other inmates in this wing, and as facilities were not provided for the isolation of convalescents the infection was communicated by them to other susceptible inmates.

2. The spoons, forks, cups, etc., used in the dining-rooms were washed by the insane inmates without boiling, and in the course of the epidemic every utensil in the building probably became infected, thereby exposing the food which entered the building to infection as soon as it was received.

3. The filthy habits of many of the insane inmates of the hospital probably caused infected discharges to be generally distributed in the bathroom, upon the furniture, doorknobs and other surfaces touched by the hands of the infected persons.

4. From the west wing the infection was carried to other portions of the main building, but, as above stated, not a single case occurred in the annex, indicating that the infection was

not conveyed by milk or water, for the supply of both of these articles was from the same sources for both buildings. The water supply for all of the buildings on the hospital premises was taken from the same piping system, and in the standpipe, located near the annex, the water which was pumped into the mains from the spring and from the wells was undoubtedly often thoroughly mixed before distribution to the various branches and service lines.

5. Inquiry has shown that communication between the infected kitchens of the main building and the dwellings of employes, where cases of typhoid fever occurred, was frequent.

RESTATEMENT.

1. Typhoid fever was brought to the State Hospital, Trenton, by an inmate who was admitted February 16, 1907, the diagnosis being made April 8. This patient was located in the west wing.

2. The roommate of the first patient contracted the disease, and also numerous other inmates in the same wing.

3. These persons were not isolated during their convalescence, and new cases continued to appear in the west wing, and the disease was undoubtedly spread from patient to patient.

4. The disease did not attack the inmates located in the annex because they were not brought into contact with infected persons.

5. The disease finally subsided when all susceptible persons who were exposed to the infection had suffered an attack.

THE Mary Kingsley Medal, instituted by the Liverpool School for the Study of Tropical Diseases to commemorate Miss Mary Kingsley, the African traveler, has been awarded, among others, to the following: Dr. Charles Finlay of Havana and Col. W. C. Gorgas, U. S. A., chief sanitary officer of the Panama Canal Zone, for their work in connection with the transmission and prevention of yellow fever, and Dr. Theobald Smith for his investigations on Texas cattle fever.

A SMALLPOX scare in Vienna has led to prohibition of public meetings and processions, and the cable states that 166,000 have already been vaccinated and that the crowds almost mob the vaccination stations in their eagerness. A number of cases of smallpox have occurred in the poorer quarters. The influence of a medical man has done much to keep smallpox active in Austria. The identity of smallpox and chicken-pox has been believed in by Austrians for more than a generation.

DR. SAMUEL G. DIXON, State Health Commissioner of Pennsylvania, issued an order on September 20 directing that sheets in the berths of sleeping cars of trains running through Pennsylvania must hereafter be long enough to turn over at the upper end of the blanket at least two feet, so as to prevent the blanket from coming in contact with the face of the occupant of the berth. The same order also directs that porters on parlor cars must not brush the clothing of passengers in the aisles of cars, but only at the end of the coach. This order is designed to protect travelers from communicable diseases.

A RECENT suit against a physician of Plymouth, N. H., for alleged malpractice in causing the death of a patient through the use of chloroform has resulted in a verdict for the plaintiff. The chloroform was administered in a surgical emergency in the case of a young boy, a practice which it was maintained by the defendant's attorney was entirely legitimate. In spite of an able argument, supported by expert testimony, a verdict was returned against the physician. It would be interesting to know what the judgment of a jury would have been in England under the same conditions, where chloroform is the anesthetic usually employed.

JUSTICE BRADY of the New York Supreme Court has affirmed the sentence of Alpheus S. Frank, an attorney, who was recently convicted of subornation of perjury by a jury in the West Chester County Court and sentenced by Judge Platt to a term of three years in Sing-Sing prison. Frank, who was formerly a chief clerk for the claim department of the New York City Railway Co., was found guilty of preparing a fake trolley suit brought by one Mae Herbert of New York against that company for damages for personal injuries. On the trial it was shown that Miss Herbert had sued under a false name, as she was in reality the wife of Abbott Woods, who was conductor of the car from which she claimed to have fallen. It was also shown that the woman was formerly a circus tumbler and contortionist, which enabled her to leap from cars at full speed without hurting herself. She had an old injury, received by falling from a trapeze, which she exhibited for the purpose of proving her case, and it is said that she had figured in several successful suits of the kind before her identity was discovered.

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A NEW RECTAL SIGN.

By A. K. Bond, M.D.,
Baltimore.

As the tongue gives evidence of disorders of the stomach, and in lesser degree of those of the upper bowel, indicating, by swelling, color changes, condition of its mucous covering, etc., diseased states, more or less similar, in the hidden parts continuous with itself, so, too, does the lower tangible portion of the rectum give testimony concerning the more remote portions of the large bowel. I will not delay to recite the well-known indications afforded by a relaxed state of the sphincter ani externus, or by hemorrhoidal, ulcerous or fibroid conditions of the bowel walls. These are sufficiently discussed in the textbooks. I desire at this time to direct the attention of my readers to transient conditions of the rectal mucous membrane, which are so clearly marked and so easily perceptible by the examining finger that they can be used as diagnostic points in an obscure case. The only drawback is that a certain loathing of rectal examinations, which formerly attached also to those made by vagina, persists in the mind of the profession and of the laity. If this has been reasoned away in the latter case, it may doubtless be in the former, in which the moral objections are, it must be admitted, much less strong. It is all a matter of training of the public thought. "Ballooning of the rectum" has been exploited, and spastic sphincter, but very little is yet known by the general physician concerning these parts.

There is a condition of the large bowel in which, if the finger be lubricated and passed to its full length into the rectum, the mucous membrane of the rectum will be found swollen, in cushiony ridges, considerably narrowing the lumen of the organ. The swollen walls cannot be compressed by the finger. They are not inflamed, not oversensitive. The ridges mentioned are merely exaggerations of the natural folds of the mucous membrane. This condition is usually, but not always, attended by tight contraction of the

lowermost sphincter. Hemorrhoids do not usually occur; the folds are not hemorrhoids.

The condition described extends doubtless throughout the whole extent of the large bowel. This is, *a priori,* probable, and is indicated by the extreme difficulty encountered in injecting enemata, especially high enemata, into the bowel; the difficulty and even impossibility of passing the rectal long tube; the inability of the cecum and adjacent bowel to propel its contents into the sigmoid and of the sigmoid to empty into the rectum. Water forced slowly and carefully into the bowel is returned by the bowel as colorless as when injected, or contains *débris* of long-retained fecal masses. Subsequent events show that the cecum, meanwhile, has considerable quantities of retained feces in it.

This condition has probably been included in the clinical descriptions of "spastic colon," but the tangible cause, in the cases of which I speak, is acute swelling of the mucous membrane of the bowel. Even when the lowest anal sphincter is sufficiently relaxed there remains often a sensation of tension in the empty rectum, and the finger still feels the tense, swollen folds of mucous membrane.

I suspect that this state of affairs is often followed by the formation of hemorrhoids if unrelieved. In the cecum masses of feces thus prevented from escaping must, if irritating, eventually do damage. Speculations as to the possible sequel in dysentery or appendicitis are of little value (facts being preferred to theories at the present day). It is worth while to note, however, that evidence obtained by digital examination, as already described, would not necessarily be set aside by that secured through autopsy or through operation under anesthesia, in either of which conditions the swelling might have subsided before inspection. This may be the reason why, in operations for appendicitis, the large bowel is so often reported to show no symptoms whatever of disorder, when it could hardly be innocent of some part in the causation. A tense swelling which, in the rectum, disturbs circulation enough to cause piles, might surely, occurring in the appendix and adjacent cecum, cause ulceration in the presence of irritating bowel contents.

Clinically, the patients who would afford this objective condition on digital exploration suffer at first little discomfort. They gradually acquire a "stuffy feeling" in the abdomen, and, if uncured, become flatulent, morbid, dyspeptic. The appetite may be lessened, or may exceed all reasonable limits. The tongue may for some time continue clean, allaying suspicions of danger. The bowels may move, after a fashion, in response to enemata, suppositories, and the feebler purges so popular nowadays, deluding the patient, and even the physician, into a belief that they have emptied themselves, or they may refuse to act at all. The urine

becomes high-colored and less abundant, irritating its channels. Neuralgias, often very severe, eventually set in.

There may be obscure distress in the course of the large bowel, especially of the cecum.

I have given to the profession my views upon the treatment of such cases, in a general way, in an article on "Complete Purgation" in the Maryland Medical Journal of April, 1896, and elsewhere. Each case demands separate study. At present diagnosis and causation are more in mind. There is fermentation of food, and there is flatulence, and there is an excess of free acid in the stomach long after its digestion should have been completed, as shown by the formation of carbon dioxide on the ingestion of sodium bicarbonate.

I believe that weather changes cause bowel congestion, fermentation, blood pollution, with artery spasm (beginning of arteriosclerosis?), kidney irritation, nerve poisoning, in this order of sequence. Sometimes I think that intestinal acidity is the cause of the large bowel irritation. Sometimes retained feces, forming hard scybala, seem to be the bowel irritant. Again, I suspect that some nerve fault with excessive irritability may underlie the whole process. A body disorder may be due to different causes at different times, or to a combination of causes. Certain it is that a patient apparently the hopeless victim of the disorder under discussion may completely recover from it during a pleasant summer vacation in the country, the bowels then acting daily in a thorough manner of their own accord.

The main point to which I now wish to draw attention is that in obscure cases of doubtful diagnosis, with or without the presence in marked degree of the symptoms which I have mentioned, a rectal examination with the finger may throw a flood of light upon the case. Furthermore, in cases where it is doubtful whether aperients have done all that is required of them, a rectal examination, by revealing this swollen condition (cushiony and incompressible) of the attainable mucous membrane, may show that complete emptying of the large bowel has not yet been secured. Believing as I do that large-bowel sepsis is at the bottom of many obscure lengthy illnesses, and the cause of distressing complications in the course and decline of many febrile diseases, I urge the more boldly upon my fellow-physicians a personal study in suitable cases of this, as far as I know, heretofore unemphasized rectal sign.

There is a field for a very interesting clinical study and monograph by some hospital resident physician with large facilities of observation: "What are the non-surgical conditions perceptible by the examining finger in rectum, and what light do they throw on large-bowel diseases?"

Current Literature.

REVIEW IN PEDIATRICS.

Under the Supervision of José L. Hirsh, M.D., Baltimore.

THE ACETONEMIC CONDITIONS OF CHILDREN. Frederick Langmead. *British Medical Journal,* September 28, 1907.

From the clinician's standpoint patients in whose urine diacetic acid and acetone may be detected by ordinary methods of examination may be classed in three groups:

Group 1. Those who usually show no symptoms of acidosis. Included among these are cases of excessive fat ingestion, starvation, high fevers, gastric ulcer, malignant disease and others, perhaps all due to the deprivation of carbohydrates.

Group 2. Those who, while the subject of other morbid states, have also symptoms of acid poisoning, which may, to a certain extent, be masked by those of the primary condition. Such are patients suffering from diabetes, a certain type of pneumonia, intracranial disease, toxic forms of gastro-intestinal disturbance, epidemic diarrhea, sepsis, intestinal obstruction, acute peritonitis and certain poisons, including morphine and salicylate of sodium.

Group 3. Patients who suffer from uncomplicated acidosis which, *per se,* may terminate fatally. These are the subjects of (a) delayed anesthetic poisoning; (b) recurrent, cyclical vomiting—conditions which may be designated as "cryptogenic acidosis."

The paper deals chiefly with the last group. The symptoms of acidosis—dullness, increasing to drowsiness and occasionally to coma, flushed face, great thirst, nausea, persistent vomiting, acetone and diacetic acid in the urine—sometimes follow in the wake of narcosis produced by anesthesia. There may be an interval of several hours between the anesthetic and the onset of acidosis, or the retching and vomiting after anesthesia may be aggravated into the symptoms mentioned. The writer adds three cases to the 100 already reported. Two of these cases followed chloroform narcosis and one nitrous oxide gas. Two cases of cyclical vomiting, with post-mortem findings, are also described. The characteristic condition found in both classes of cases is the far-advanced fatty degeneration of the liver. Langmead sums up this interesting communication as follows:

1. Acetone and diacetic acid are found in the urine in a number of conditions, and may be, but are not necessarily, associated with symptoms of acidosis.

2. Cyclical vomiting and delayed anesthetic poisoning are examples of acidosis of unknown origin.

3. Delayed anesthetic poisoning is due not so much to the kind of anesthetic used as to the state of the anesthesia.

4. The acetone series is a product of the imperfect oxidation of fats, and hence in these conditions the oxidizing power of the tissues must be inadequate.

5. This is further demonstrated by the condition of the liver.

6. There is evidence in favor of the failure of oxidation being due to too great a supply of fat to the chief seats of oxidation rather than to a primary deficiency in oxidizing power, although the latter alternative cannot be excluded.

7. Probably this may be brought about by a variety of toxins which act like phosphorus.

8. The determining cause of acidosis is the accumulation of the precursors of acetone, either from excessive formation or deficient excretion.

9. Anesthetics are dangerous to patients who are the subjects of acidosis.

The treatment which is the outcome of these conclusions is, first, to inquire into the previous condition of the patient, especially with regard to bilious attacks, before administering an anesthetic, and secondly, to examine the urine for acetone and diacetic acid. If either is elicited, a course of alkalies should be administered before the operation. Ether should be the anesthetic selected, as chloroform is especially dangerous, due to its specific action on the liver and kidneys.

* * *

Some Points in Infantile Tuberculosis. L. Emmett Holt. *Archives of Pediatrics,* September, 1907.

The writer calls attention to the importance of the examination of the sputum in infants in the diagnosis of tuberculosis. Of 67 cases of pulmonary tuberculosis treated in the past 19 months, 62 were in infants under two years of age and 16 under six months of age. The diagnosis rested upon finding the bacilli in the sputum in 54 of these cases, upon post-mortem findings in 10, and of the remaining three, one had tuberculous meningitis (bacilli found in the fluid drawn by lumbar puncture), one reacted to tuberculin, and the third gave typical clinical symptoms of pulmonary tuberculosis. In only one-half of these cases was there any consolidation present at the time the diagnosis was made. In order to obtain the sputum for examination a cough is excited by irritating the pharynx, and the secretion brought to view is swabed out by a small piece of muslin held in an artery clamp.

As to the source of the infection in these cases, in 29 there was a rather definite history of tuberculosis in the parents or some member of the household. The large proportion of the cases showing household infection shows that the infant seems to be rather more frequently infected than the older children of the

family. The infrequency of the presence of intestinal ulcers in infants, in spite of the fact that the sputum is swallowed, would seem to point to the opinion that the intestinal tract is not vulnerable to tuberculosis at this period of life.

The foregoing observations tend to confirm the opinion that it is direct contagion which is responsible for most of the tuberculosis of infants rather than infection through milk or other foods.

The results of the study of the spinal fluid in lumbar puncture in tuberculous meningitis also gave valuable information as to the possibility of obtaining the bacilli. Of 42 consecutive cases of the disease the bacilli were found in every case. Some important points in technique have been developed in the course of this study which are of assistance in finding the bacilli. In withdrawing the fluid it was found advisable to collect the amount in several tubes, since the bacilli are more apt to be found in the last portion drawn than the first, probably because the bacilli are present in large numbers in the brain and come down with the last portion of the fluid. The bacilli were usually more numerous in late punctures than in those made in the early stage of the disease. The following technique of search is given followed in this series:

The fluid is allowed to stand in the test tube for 12 hours. If a film forms by the coagulation of fibrin in the fluid, this is fished out with a platinum loop and stained. Such film formation occurred in about half of the cases, and in it the bacilli are pretty certain to be entangled. If no film forms, the sides of the tube are scraped with a platinum loop. If the bacilli are not found in this way, the fluid is centrifuged. The chance of success after centrifuging are greatly increased by adding a drop of blood.

Of the 42 cases showing the bacilli in the cerebro-spinal fluid, 22 also showed the bacilli in the sputum, although 9 of them showed no evidence whatever in the chest, and in only 5 was there any consolidation.

* * *

THE AUSCULTATORY AND PERCUSSION FINDINGS OF THE HEART IN LATE CHILDHOOD. William J. Butler. *American Journal of the Medical Sciences,* July, 1907.

The heart findings in a physical examination are often misinterpreted in late childhood owing to two factors—the comparatively large cardiac area and the frequency with which murmurs are heard over the heart at this time. The author gives the results of the examination of 100 healthy children from this point of view.

To sum up the findings in the 100 children examined, it may be stated that the upper border percussed in the parasternal line is most frequently found on the third rib, less often in the second or third interspace; that the right border may extend 0.5 to 2 cm. to the right of the sternum, as indicated by a slight relative dullness only, and that the apex, while most frequently found in the fifth

interspace inside the nipple line, may be found outside of it. It is seldom in the fourth interspace, in which event it is as often inside as outside the nipple line. It will be noted that in changing from the erect to the dorsal position no change is found in the level of the upper or right border in about 45 per cent. of the children, and that in many of the remainder a difference of 0.5 to 2 cm. was found either in elevation of the upper border or diminishing of the right border, there being no parallelism in the changes in these borders in most of the children. In a few children the upper border was lowered in the recumbent position. In regard to the position of the apex, in more than half it remained unchanged, though at times it became less distinct; in others it ascended the width of an interspace or a rib, or of both, and in a few instances, without changes in horizontal level, it glided slightly to the left.

The differences in the cardiac area, as found in the erect and the recumbent positions, undoubtedly depends upon the elevation of the diaphragm and gravity.

In auscultation over this area murmurs were heard in 64 cases. Of this number, in only 18 were they heard in the erect position, leaving 46 in whom they were audible only in recumbency. Murmurs heard in the erect persisted in the recumbent position. The murmurs were much influenced by position. Those heard over the pulmonic area and the apex were usually intensified on placing the child on the left side. The murmurs varied considerably at times in loudness under the auscultating ear, were sometimes inconstant, and frequently disappeared at the height of the inspiration or were greatly diminished in intensity, being usually heard best during the expiratory phase. From the mentioned characteristics of these murmurs it is evident that they do not conduct themselves as do organic murmurs, which are not markedly influenced by position or the respiratory movement. The writer looks upon them as accidental murmurs, dependent on the relation of the heart to its environments; in other words, we are dealing with extracardiac, paracardiac or cardiopulmonary murmurs occurring in the systolic phase of the heart cycle.

* * *

Pneumococcus Arthritis in Infants and Children. A. F. Furrer. *Archives of Pediatrics,* July, 1907.

The object and scope of this paper are:

1. The report of a case of pneumococcus arthritis in an infant 16 months old.

2. The tabulation of 26 previously-recorded cases of pneumococcus arthritis occurring in infants and children.

3. The presentation of a summary from a study of the literature.

From a study of the reported cases of this specific form of arthritis occurring in childhood it is noted that the joint involve-

ment is secondary to a pneumonia in about one-half of the cases. In 25 per cent. of the cases the joint lesions followed otitis media, bronchitis or measles. In 25 per cent. of cases the arthritis was apparently primary. On the other hand, pneumococcus arthritis in the adult is secondary to a lobar pneumonia in about 90 per cent. of the cases. A few cases have been reported in which the pneumonia followed the joint invasion, and three or four cases have been reported in which arthritis was the primary lesion. This comparison shows in a striking way the apparently much greater vulnerability of the joints in the young to septic infection.

The writer gives the following points as to diagnosis and differential diagnosis:

1. An acute arthritis occurring in an infant or child coming on from 3 to 14 days after the onset of a pneumonia, and accompanied by pain and swelling, may be suspected to be a pneumococcic arthritis.

2. An acute or subacute arthritis developing without signs or history of pneumonia may be due to the pneumococci.

3. An acute osteomyelitis generally shows more profound constitutional symptoms. Pain is more likely to be referred to the shaft or epipheses.

4. Acute articular rheumatism is very rare in infants and uncommon in young children. A high leucocyte count favors arthritis of pneumococcic origin.

5. Tuberculous arthritis is insidious in onset and chronic in course, generally monoarticular.

6. Gonorrheal arthritis is less acute in onset.

THE PRACTICE OF PEDIATRICS. By American and English Authors. Edited by Walter Lester Carr. Illustrated with 199 Engravings and 32 Full-Page Plates. Philadelphia and New York: Lea Brothers & Co.

The list of contributors comprises some well-known names in the field of pediatrics. While most of the diseases pertaining especially to infants are treated in a rather comprehensive manner, some are a little too brief to be of any great advantage. The article on infant feeding is especially well handled and covers the ground admirably from the general practitioner's point of view. The general principles involved in substitute infant feeding are clearly brought out, and many small points, which make the difference between success and failure, are dwelled upon. Diseases of the intestinal tract and infectious diseases occupy a large portion of the volume, as one would expect, and while most of the well-recognized conditions are satisfactorily handled, we observe nothing especially new. The diseases of the blood, lymphatic system and glands are considered in a clear and concise manner. We think it would be better not to consider skin diseases rather than devote but 25 pages to it, most of which is taken up with illustrations and formulae. The book is well printed, making it rather agreeable to read.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

$50,000

TO BE RAISED BY APRIL, 1908

"Watch It Grow"

	1st Wk.	2d Wk.	3d Wk.	4th Wk.	Totals.
March.....					
February					
January.....					
December.....					
November					
October	$480				

Subscriptions to October, 1907	$4,273.00
Friedenwald Fund.....	$1,246.87
Osler Fund.....	$19,129.00
Value of Present Realty.....	$18,000.00

NOTICE.

THE active campaign, which began October 4th., to raise funds for the new medical library building, is being pushed with renewed vigor this year; and it is expected not only to have the $50,000 in hand by April 1908, but to be able to announce at that time the completed fund and plans for the building.

The enthusiastic support of every member of the Faculty, both in the cities and counties, is needed and we expect will be forthcoming.

The Committee has planned to graphically show the progress on large charts, showing "blocks" in the new building with the donor's name on them; these blocks will represent $10.00 each or more according to amount of gift. A chart with a completed building on it (see illustration), showing in the beginning a splendid foundation, will announce the weekly and monthly progress, which we hope will be most rapid.

A list of the names of the paid subscribers, previous to October 4th., is to appear this month, and each month thereafter the new names will be given and full progress of the work.

It is earnestly hoped that all members when going to the Faculty building will be sure to see that their names are entered upon the book there and the questions in it, as regards the new building, answered. At least *put* your name down even if you don't do *anything* else. This will help the Committee greatly and aid in the work.

A BENEFIT performance for the New Building Fund is to be given on Tuesday, December 3d. at Ford's Grand Opera House. The play is one of the latest and best musical comedies called "Comin' Thro' the Rye." All must try to be present on medical night and make it a great success. Tickets will be sent out in advance or may be obtained from any member of the Committee or at the Faculty building. A list of patronesses of the occasion will be published next month.

All communications and inquiries concerning the New Building may be addressed to Dr. John Ruhräh, 847 N. Eutaw St. and all subscriptions, either pledges or payments, may be sent to him. Make all checks payable to the Building Committee of the Medical and Chirurgical Faculty of Maryland.

PAID SUBSCRIPTIONS TO THE NEW BUILDING FUND.

Dr. L. McL. Tiffany	$1000.00
Dr. Chas. O'Donovan	200.00
Mr. W. A. Putnam	100.00
Dr. L. F. Barker	50.00
Dr. C. B. Gamble	50.00
Through Dr. M. Lazenby	50.00
Dr. H. W. Gaddess	25.00
Dr. E. Kerr	25.00
Dr. J. A. Chatard	25.00
Dr. A. P. Herring	25.00
Dr. H. M. Simmons	10.00
Dr. J. S. Garrison	1.00
Dr. J. S. Fischer	1.00

PAID SUBSCRIPTIONS TO THE OSLER TESTIMONIAL FUND.

Parmell, Mr. James, 720 "The Cuyago," Cleveland, Ohio.	$250.00
Paton, Dr. Stewart, 6 Princess St., London, England	100.00
Pearce, Dr. Wilbur, 1238 Greenmount Ave., Balt.	5.00
Phipps, Henry, Esq., City of Mexico, Mexico	1000.00
Pleasants, Dr. J. Hall, 16 W. Chase St., Balt.	100.00
Pole, Dr. A. C., 2038 Madison Ave., Balt.	50.00
Punton, Dr. John, 18th. St. and Lydia Ave., Kansas City.	10.00
Randolph, Dr. Robert L., 816 Park Ave., Balt.	10.00
Reinhard, Dr. Ferdinand, 1400 Linden Ave., Balt.	5.00
Riely, Dr. Compton, 4 W. 20th. St., Balt.	10.00
Sadtler, Dr. Charles E., 1415 Linden Ave., Balt.	100.00
Scott, Dr. J. McP., Hagerstown, Md.	10.00
Scott, Dr. N. B., Hagerstown, Md. (Deceased)	10.00
Seligman, Dr. J. A., 1920 Linden Ave., Balt.	5.00
Shattuck, Dr. F. C., 135 Marlborough St., Boston, Mass.	100.00
Smith, C. U., 1928 Madison Ave	10.00
Smith, Dr. Frank R., 1126 Cathedral St.	100.00
Smith, Dr. Wm. T., Hanover, N. H.	5.00
Steele, Dr. Herbert M., Montreal, Canada	25.00
Stokes, Dr. Wm. Royal, 1639 N. Calvert St.	25.00

PROPOSED ITINERARY FOR DR. McCORMACK'S TRIP THROUGH MARYLAND.

Tuesday, Nov. 19—Elkton, Cecil County.
Union meeting Cecil and Kent Counties.
Wednesday, Nov. 20—Easton, Talbot County.
Union meeting Talbot, Queen Anne and Caroline Counties.
Thursday, Nov. 21—Cambridge, Dorchester County.
Friday, Nov. 22—Salisbury, Wicomico County.
Union meeting Wicomico, Worcester and Somerset Counties.
Monday, Nov. 25—Westminster, Carroll County.
Tuesday, Nov. 26—Towson, Baltimore County.
Wednesday, Nov. 27—La Plata, Charles County.
Union meeting Charles and St. Mary's Counties.
Friday, Nov. 29—Bel Air, Harford County.
Saturday, Nov. 30—Ellicott City, Howard County.
Monday, Dec. 2—Cumberland, Allegany County.
Union meeting Garrett and Allegany Counties.
Tuesday, Dec. 3—Hagerstown, Washington County.
Wednesday, Dec. 4—Frederick, Frederick County.
Thursday, Dec. 5—Rockville, Montgomery County.
Friday, Dec. 6—Laurel, Prince George County.
Saturday, Dec. 7—Annapolis, Anne Arundel County.
Monday, Dec. 9—Prince Fredericktown, Calvert County.

COUNTY SOCIETY MEETINGS.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY.

THE regular quarterly meeting of the Anne Arundel County Medical Society was held on Tuesday, October 8, in the Maryland Hotel parlors. Dr. Harry B. Gantt, of Millersville, President, presided, and Dr. Louis B. Henkel, Jr., of Annapolis, was Secretary.

There was general discussion on the subject of ovarian abscesses and obstretrical cases. The Medical Society formulated a plan to secure a home in which to hold their regular quarterly meetings. No definite arrangements were made.

The following physicians were present: Dr. H. B. Gantt, Millersville; Dr. C. R. Winterson, Hanover; Dr. J. M. Worthington, Dr. Walton H. Hopkins, Dr. J. O. Purvis, Dr. F. H. Thompson, Dr. Louis B. Henkel, Jr., all of Annapolis, and Dr. Thomas H. Brayshaw, of Glen Burnie.

The meeting adjourned subject to the call of the President. Some of the doctors, after the adjournment of the meeting, took luncheon at Hotel Maryland.

PRINCE GEORGE COUNTY MEDICAL SOCIETY.

THE regular meeting of the Prince George County Medical Society was held at Aman's Hall, Washington, D. C., at 1 o'clock, September 18th.

After luncheon, Dr. Dufour of Washington gave an interesting address on "The modern method of tonsillotomy" and demonstrated the new instruments used for the operation. He also demonstrated the method of operation for the removal of foreign objects from the trachea, bronchi and esophagus.

HOWARD COUNTY MEDICAL SOCIETY.

The regular quarterly meeting of the Howard County Medical Society was held at the Howard House, Ellicott City, Md., October 2, 1907.

After a luncheon served at the hotel, the meeting was called to order at 3 P. M. by Dr. Wm. B. Gambrill, President.

The minutes of the last meeting were read and adopted.

A strong talk on "State medical organization and its relation to the county society" was given by Dr. Charles O'Donovan, President of the Faculty.

The following members were present: Drs. Wm. B. Gambrill, J. W. Lacy, S. A. Nichols, S. J. Fort, W. C. Stone, L. G. Owings, F O. Miller, and A. Williams.

ALLEGANY COUNTY MEDICAL SOCIETY.

The Allegany County Medical Society held its annual business meeting, Wednesday, October 2d.

The following officers were elected:

President—Dr. Geo. L. Broadrup, Cumberland.

Vice-President—Dr. Abbott R. Walker, Frostburg.

Secretary and Treasurer—Dr. Wm. R. Foard, Cumberland.

Delegate to State Society—Dr. E. B. Claybrook. Alternate—Dr. A. Leo Franklin.

Committee on Public Health and Legislation—Dr. S. A. Boucher, Barton; Dr. E. H. White, Cumberland; Dr. Edward Harris, Cumberland.

Two new members were admitted: Dr. Henry M. Hodgson, Lonaconing; Dr. James O. Bullock, Lonaconing.

At the meeting next month the druggists will be invited to discuss important local subjects.

MONTGOMERY COUNTY.

The semi-annual meeting of the Montgomery County Medical Society was held October 15 in Grange Hall at Olney, and proved a successful and pleasant gathering. The society was the guest of the Doctors' Club of the Sandy Spring neighborhood, and at noon was entertained at a bountiful luncheon, provided by wives and daughters of the members of the club.

The session was presided over by Dr. James E. Deets of Clarksburg, who is president, with Dr. William L. Lewis of Kensington acting as secretary. The other physicians present were Drs. Edward Anderson, O. M. Linthicum and C. H. Mannar of Rockville, Roger Brooke of Sandy Spring, W. F. Green of Brookville, H. B. Haddox of Gaithersburg, Augustus Stabler of Brighton, James Dudley Morgan of Chevy Chase, W. E. Magruder of Sandy Spring, Charles Farquhar of Olney, Mahlon Kirk of Oakdale, L. B. Thomson of Silver Spring, J. R. Batson of Spencerville, W. S. Gardiner of Baltimore and Dr. Nichols of Howard county.

The following physicians were elected to membership: Drs. A. V. Parsons of Takoma Park, F. N. Henderson of Clarksburg, J. R. Batson and L. B. Thomson.

Dr. Gardiner read an instructive paper on gynecology, and Dr. Stabler delivered an interesting address on chronic ulcer of the stomach.

Announcement was made that a public meeting will be held in Rockville on December 5, at which time Dr. J. H. McCormack, representing the American Medical Association, will deliver an address on "Something about Physicians that the Public Ought to Know." Dr. McCormack is an able man, and this address will attract wide attention. A committee on arrangements for this meeting was appointed consisting of the resident physicians of Rockville and the president and secretary of the County Medical Society.

On motion of Dr. Lewis, the committee on legislation was instructed to use every effort to secure sanitary inspection of the milk supply of this county by State authorities.

The committee was also instructed to secure, if possible, free treatment at the Pasteur Institute for indigent patients exposed to hydrophobia.

PAPERS READ AT THE ANNUAL MEETING APRIL 23-25, 1907.

ANNUAL ORATION.

By G. H. Simmons, M.D.,

Chicago.

(*Continued from the October number.*)

CANNOT PUBLISH BLACKLIST.

It has been suggested that the Council print a list of the preparations that have been refused recognition, since there are many who have intimated that they would not prescribe or recognize in any way the rejected articles. This is impracticable: First, because the number is too large; second, because the Council hopes that some may reform or be withdrawn without necessitating a resort to extreme measures, and, third, because it might and undoubtedly would involve us in lawsuits. A blacklist is not a safe thing to make public.

The Council is publishing from time to time reports condemnatory of preparations, with comments, but this has to be done with great caution; every statement must be verified or injustice might be done. Further, the function of the Council is to approve rather than to condemn. When it does condemn and publishes its condemnation, it is for a specific purpose, that purpose being to educate physicians by presenting concrete examples of the way they are being imposed on.

CHEMICAL LABORATORY.

A chemical laboratory has been established in the association building and is in charge of the secretary of the Council, Professor Puckner, and an assistant. While it is not possible to do a great amount of chemical work in this laboratory, it will be of great advantage in many ways.

In connection with the movement much information relating to

the general subject has been gathered. This has been classified, indexed and made available for the future. This, in fact, is one of the important features of the work being done in the central office. In the past considerable matter has been published showing the fraudulent character of products manufactured not only in this country, but in Germany and abroad generally. Such matter has usually been published in drug or chemical journals and has never come to the attention of physicians—the very ones who should have been informed.

The important drug and chemical journals of the world are taken for the laboratory, and the information obtained from them is most valuable. It is needless to say that hereafter physicians will be informed of matters which concern them that appear in this class of journals.

In connection with the laboratory is an information bureau, in one division of which advertising literature has been collected and classified. This includes booklets, circulars, advertisements and write-ups in medical journals, etc., covering the last five years. The exhibit is interesting and instructive for those who want to make a study of this nostrum business, and will furnish texts for future sermons in the propaganda for common sense in therapeutics.

Another division directly related to the above is a card index of those who have given testimonials or furnished write-ups of proprietary preparations. These cards are made up in great part from the matter on file. This division also is most interesting. While it contains the names of a few excellent men, the great majority are hardly known in their own locality, and yet their opinions are accepted without question by intelligent, well-educated practitioners. Some seem to have a habit of giving testimonials for all kinds of things, and it requires considerable space to record the references. It is encouraging to note that this exhibit is not growing so fast as it was. Evidently, testimonial giving is not so popular as it was previous to a year and a half or two years ago.

It is well known that while the *name* of a product does not change, the *composition* of the product may, and does. To be able to show this in the future, samples of many proprietaries are preserved, with date of receiving, etc.

CO-OPERATION OF OTHERS.

One favorable development is the co-operation of other workers in similar fields. A number of chemists in universities, schools of pharmacy, etc., have volunteered to assist, and it is expected that in the future the aid of such men will be of great advantage in solving questions on which they are especially well qualified to pass. Several State and municipal boards of health are doing good work, and exchange of information with these is now a feature. This promises to develop in the future to the mutual benefit of these boards and the Council. It is hoped, in time, to interest teachers in medical colleges; such help is sorely needed.

The advantage to the Council of having as members Dr. Wiley, chief of the Bureau of Chemistry, and Dr. Kebler, chief of the

Drug Laboratory, has been very great, for it has received not only their personal aid, but also material assistance from the departments with which they are connected. In fact, without the aid of these laboratories some of the work done would have been impossible. The profession is also under great obligations to Surgeon-General Wyman, who permitted Dr. Reid Hunt to serve as a member of the Council. Through Dr. Hunt's connection with the Hygiene Laboratory of the Public Health and Marine Hospital Service, and with the permission of Surgeon-General Wyman, it has been possible to refer certain intricate problems to that laboratory that otherwise would have been difficult of solution.

FOREIGN CO-OPERATION.

Another promising feature is the fact that the Council is getting in touch with workers abroad. For instance, splendid work is being done in Berlin, especially in the investigation of the synthetic chemical compounds under the auspices of the German Apothecary Society. This is directed by Professor Thoms of the Pharmaceutical Institute of the University of Berlin, a chemist of international standing. Correspondence with Professor Thoms has been carried on for some months, and he has offered to assist the Council whenever possible. At the request of the Council, the Board of Trustees of the American Medical Association has just elected him a corresponding member of the Council.

Professor Cushny of the University of London has been a corresponding member since he left this country, soon after the Council was organized.

It is hoped very shortly to get similar foreign correspondents in Paris, Switzerland and in other countries. Such co-operation will be of great assistance in dealing with foreign products.

One of the conditions which the Council has had to meet is the exploitation of foreign goods by American agents who advertise them, sometimes innocently, under claims that are not accepted abroad. In some instances products had been sold abroad under claims regarding the composition that were shown to be false. Over there the manufacturers were compelled to modify their statements, but the old claims are still being made here. The Council has already secured a modification of the literature relating to certain foreign products by calling the American agents' attention to the fact that if such modifications were not made the actual facts regarding the preparation would be published.

A large number of preparations made here are advertised as being made abroad. Further, some are made abroad for the American market that have absolutely no sale in the country in which they are made. In due time evidences of these facts will probably be given to the profession.

I have given a brief review of the conditions which led to the organization of the Council, have outlined the principles or rules by which proprietary articles are judged, and have spoken of the mode of procedure. I have not told you of the difficulties the Council has encountered, and I think this hardly necessary, for I am sure all know without being told that these difficulties have been very great.

CONDITIONS ALREADY IMPROVED.

The work has been going on for a little over two years. To all appearances there are just as many nostrums on the market and the advertising pages of certain medical journals are just as well filled with this class of medicines—in fact, if the truth must be told, better, and for reasons that should be evident. But in spite of this apparent evidence of prosperity, if one looks beneath the surface, one will find that a change has taken place. There has been a gradual decrease in the number of write-ups of proprietaries; there is evidence that physicians are thinking, that they have developed a healthy skepticism and no longer believe all that is told them about the wonderful cure-alls they are asked to prescribe. The detail men do not have such willing and credulous listeners. There has been a remarkable falling off in the sale of "ethical" proprietaries, especially those of the typical nostrum type. This is common knowledge to those in touch with the trade. A comparison of the catalogues of some of the manufacturing houses in circulation two years ago with those of today will reveal the fact that not a few of the "specialties" are missing. And the descriptive matter, formulas, etc., of many others are different from what they were. A part of this is explained by the national Food and Drugs Act, but only a part. Many of the changes had taken place before this law was passed.

The influence of the Council in this connection has been greater than will ever be known. The knowledge that our profession is at last awake, that it has a body to expose the frauds that may be imposed on physicians has aroused some of the manufacturers at least to realize that old conditions have changed. The advertising literature is scrutinized more carefully; positive cures for incurable diseases are not so common.

"WHAT ARE YOU GOING TO DO ABOUT IT?"

This much has been accomplished; and yet what does it amount to compared with what must be done before American medicine is rid of the nostrum blight? The work has really just commenced. The exposès that have been made and the publication of facts regarding the nostrum business have made a large minority of the physicians think. But it is evident that much more must be done to arouse them to act. And this brings us to the question, "What is the profession going to do about it?"

The Council is purely an advisory body; there is no national, State, county, city or any other law that will compel the manufacturer to recognize it or to comply with its requirements. Hence, without the support of our profession its work will be of no permanent value. But this must be more than a passive support. Simply endorsing the work by words, by commendation or by that indefinable something called moral support, is well enough so far as it goes. But if definite, permanent, tangible results are to follow, the profession must act. If the profession does not act and does not back up this movement, rest assured we shall in time drop back into the old conditions, or into even worse.

HOW THE PHYSICIAN CAN HELP.

This movement was inaugurated directly for the benefit of the medical profession, and indirectly for the benefit of the public. There is no question as to the final success of the propaganda, but the work will be greatly facilitated if you who are interested will:

First—If you use proprietaries, secure the list of approved preparations and, all things being equal, give those in the list preference in prescribing. This list, with a description of each article, costs but a few cents; without the description it may be had for the asking.

Second—Write to those whose preparations you are using and ask if the articles have been submitted to the Council; if submitted and refused recognition, why? and if not submitted, why not? Bear this in mind: The manufacturers will recognize the Council and ask to have their controlled products placed in the book if physicians insist that they desire this; otherwise, they will do neither.

Third—Ask detail men who call if the preparations represented have been approved by the Council, and if not tell them that until this has been done you do not care to take time to examine the product.

Fourth—Look over the advertising pages of the medical journals you are supporting—editors and publishers have great respect for the opinion of their subscribers—and write and ask for a square deal in the advertising, as well as in the reading pages.

Will it be out of place for me to suggest here that the members of the Council have a right to ask for your support, when they are working absolutely without pay? Is it presumed that they will keep on indefinitely and submit to jeers and sneers if those whose interests they serve do not themselves do their share?

I am sure that every intelligent physician, unless he has some interests on the other side, believes that the movement is a good one, and deserves all the support the profession can give it. I am also sure that every one of you believe this. But—what are you going to do about it?

Let me repeat: Moral support alone will not win this battle.

THE INDICATIONS FOR SURGICAL INTERVENTION IN THE TREATMENT OF CHRONIC SUPPURATIVE OTITIS MEDIA.

By H. O. Reik, M.D.

(Abstract.)

Dr. Reik explained the pathology of this disease and referred to the various methods of treatment, according to the conditions encountered in different cases. The prognosis of chronic suppurative otitis media was stated to be good if proper methods of treatment were employed, and he expressed the belief that if due care was exercised in diagnosticating the factors accountable for chron-

icity in each case and conscientious efforts made to remove or overcome them, that only a small minority of even the most chronic ottorrhoeas would require the so-called radical operation. He believed that this operation should properly be held in reserve as a last resort for those cases which do not succumb to milder forms of treatment or simpler surgical measures. He weighed carefully the risks of the operation, under which heading he considered possible mortality from the operation, possible facial deformity, failure to cure the otorrhoea and further impairment of the hearing, and, balanced against these risks, the well recognized danger of such serious complications as may arise from leaving the disease untreated, *i.e.*, cerebral abscesses, meningitis and otitic septicaemia.

After carefully considering all of these points in detail he offered the following rules for guidance when considering the treatment of persistent chronic suppurative otitis media:

1. Broadly speaking, practically every case of suppurative otitis media is assumed to be susceptible of cure by one means or another.

2. Every case of chronic suppurative otitis media, without symptoms of intracranial invasion, should be treated patiently and persistently for a reasonable length of time, *but not indefinitely,* by well directed efforts at cleanliness and antisepsis through the external auditory canal. When it becomes evident that these simple measures or minor operations cannot cure the disease, tympano-mastoid exenteration should be advised unless in a given case there exists some special reason to justify delay and the risks of the disease.

3. The possible dangers of the operation are believed to be far less than those of the disease.

4. The patient should be told that not every case is curable, even by an operation (the percentage of cures in the obstinately chronic cases probably approximating 70 per cent.), that the hearing power will probably not be improved and may be somewhat impaired, but that the serious nature of his disease warants surgical intervention as a prophylactic measure.

PROPRIETARY AND PATENT MEDICINES.

By Louis B. Henkel, Jr., Ph.G., M.D.,

Annapolis, Md.

Mr. President and Members of the Medical and Chirurgical Faculty of Maryland:

The subject of my paper, to which I will ask your indulgence, is "Proprietary and Patent Medicines." I will endeavor to point out a few of the erroneous ideas, not to speak of the unpardonable mistakes made by our profession and the laity, taking up the different classes of preparations for the purpose of pointing out their utter uselessness, with a brief summary of their ingredients.

To begin, gentlemen, I do not want to be misinterpreted, and I

hope that those present will think along the right lines, with a view of lessening the great public evil, namely: Home medication by the laity. Most of the Patent and Proprietary remedies are based on the same drugs as are employed by the regular profession, the great dangers in their use being:

1st. The probability of neglecting indications that do not appear from a superficial and unskilled diagnosis.

2nd. The impossibility of pushing powerful drugs in emergent cases without close supervision, and in general the impossibility of applying a ready-made formula to any particular case with more than a mathematical probability of accomplishing the desired end.

3d. The TOXIC action of the medicine itself, while acute poisoning is guarded against, cumulative action often results in chronic poisoning, not to speak of syrups and other componants, which can scarcely be considered toxic in their action (in the ordinary sense), yet they often produce derangements of digestion, chronic inflammatory changes and other complications.

The first two objections I have mentioned must be understood as applying to all of the various kinds of nostrums to be discussed, while the mere citation of ACTIVE DRUGS will suffice to suggest their well known toxic action, of which time does not allow a detailed description in this paper.

In those preparations which are sold under the names of STOMACHICS, SPRING-OF-THE-YEAR Medicines, Liquid Substitutes for Temperance Advocates, Supporters during such critical periods, as Menstruation, Pregnancy, Lactation, the Menopause, or during periods of strain or overwork, contain usually one or more of the Aromatic Bitters, which we must confess are comparatively harmless, but they have in combination with them considerable amounts of Alcohol. This may and in many cases does lead to ALCOHOLISM, and if their use is continued may cause gastro-enteric catarrh or possibly an overstimulation of peristalsis, either clonic or tonic.

They are of value only as temporary spurs to digestive secretion, motility and possibly to absorption.

The various DYSPEPSIA cures which are on the market in a great many instances contain one or more of the bitter tonics, and not a few of the foregoing are styled also anti-dyspeptics. However, the animal and vegetable digestive ferments are not prepared for lay use on any considerable scale, as the ferments of the body are almost the last factors to yield to organic and functional disturbances. Such drugs are thus rarely indicated, though they are employed almost as much and as irrationally by the medical profession as by the laity. Such drugs fail to start at the root of the trouble and they weaken the natural and spontaneous strength of the body, by supplying an artificial and transient substitute, as you all will agree; necessity has been the stimulant for many wonderful discoveries in the various branches of science. This also is true to a greater or less degree with the digestive organs.

The use of patent COUGH SYRUPS, CONSUMPTION and ASTHMA CURES is becoming, sad to say, greater and greater. Many of these contain opiates in the form of morphine, codeine, heroin or else some seditive drug like atropin. It should, however, be remembered that they are no worse than the various heroin preparations which have recently been put on the market and are used very extensively by the regular profession. Some few of these preparations are innocuous. The croup cures contain ipecac, tartar emetic either alone or in combination, and some contain even apomorphine, which you all will agree is decidedly dangerous in the hands of the layman.

Asthma nostrums are often sold in pairs, liquids for internal use, and powders or papers for fumigation and inhalation. The former contain grindelia, lobelia, hyoscyamus, stramonium and the like; the latter contain usually the alkaline nitrites, stramonium leaves, etc. The more modern quacks employ nitro-glycerin and amyl-nitrite. As asthma is known to include such diseases as chronic bronchitis and emphysema and is the expression of the most diverse constitutional conditions, such as renal and cardiac failure, also the various perversions of nutrition, organic central nervous lesions, peripheral nervous influences, as reflex from the ovaries, cervix uteri, rectum, gall bladder and the like; it is therefore obvious that the direct treatment of the spasms of the bronchioles, however well applied, is a small part of the radical treatment of the disease, and the temporary relief they may afford causes the sufferer to refrain from seeking professional advice when it is absolutely necessary.

For Catarrh cures I must say the old fashioned snuffs are now almost obsolete. The nasal douches, unless very carefully employed, are apt to injure the Schneiderien membrane, even with a saline solution, hence even the quacks have mainly abandoned their use, and now use sprays of various kinds, chiefly watery solutions of alkalies, mild antiseptics and astringents and solutions in mineral oil of menthol, eucalyptol and camphor. Many of the hydrocarbon bases are imperfectly refined, but on the whole it is mainly in the failure of nice discrimination that the proprietary sprays, etc., differ from those used by most practitioners.

Inhalations, whether used with a tube or intended to be breathed from the hand or from hot water, or whether pungent drugs like cubebs are burned in a cigarette, are very similar to similar preparations of ethical standing. In all such medicaments we, however, need to guard against excessive use, especially when phenol (carbolic acid), iodine and astringents are contained in them.

SOOTHING SYRUPS: These are practically always syrups of opiates or occasionally milder depressants, such as the bromides. Even the lay press has been instrumental in warning against their use, and I must say that the mother or nurse who employs them is decidedly ignorant and depraved. Their baneful effect is threefold: immediately upon the nervous centers and digestive organs, which ultimately tends to produce chronic ner-

vous and nutritive weakness, which may be lifelong; hence, gentlemen, you see the need for timely and stringent warning to the lay people.

RHEUMATISM CURES: Which have been widely advertised for many years, contain one or more of the cheap alteratives; the older ones contain alkalies, rhus toxicodendron, phytolacca, iodides and sarsaparilla; the newer formulas contain salicylates, variously combined. Most vegetable alteratives are comparatively harmless and inert, but phytolacca, the iodides and salicylates are toxic if taken continuously. As is well known, rheumatism as diagnosed by the laity includes chronic rheumatism, myalgia, neuralgia, neuritis, pain due to organic diseases, tertiary syphilis, tubercular and surgical diseases of bones and joints, the majority of which may terminate very seriously if neglected; hence the necessity for a correct diagnosis.

The CURES FOR SYPHILIS AND BLOOD DISORDERS: These are usually advertised so as to include chronic rheumatism, acne and the most diverse conditions. Mercury is seldom included in the more modern nostrums on account of the impossibility of controlling its ingestion, without elaborate warnings, that might alarm prospective users. Iodides are usually contained in these medicines, even the Sarsaparillas and "purely vegetable compounds" being said to contain them in most instances. With the uncertainty of their usefulness, and the undoubted misleading effect, we should make every effort to guard against their use.

SKIN CURES: Those for external use consist mainly of sulphur in a mild antiseptic wash and are probably harmless, though of little value except in acne. The internal remedies are mainly based on arsenic, and the danger of systemic poisoning, including the setting up of chronic nephritis and also of producing ultimately a thick, crackly hide, amounts almost to a certainty; therefore let us do what we can to lessen their use.

GENERAL TONICS: These comprise iron, manganese, strychnine, quinine, so called "BEEF, WINE AND IRON," and so on, some of which are genuine and some of which contain cheap mixtures of iron, alcohol and proteid. This class also includes alcoholic bitters, variously altered, cod liver oil emulsions, malt preparations, which may be nothing more than beer on the one hand and molasses on the other, and the preparations of hypophosphates and phosphates, the compositions of which are uncertain, though it will be seen that very few of these are apt to produce serious toxic symptoms. However, there is great danger of minor disturbances of digestion being caused, and with the ones containing alcohol it may be the beginning of the habit.

HEADACHE REMEDIES: While the older ones were chiefly saline cathartics, the modern ones are nervines divided into two classes: powders containing acetanilid or some similar coal-tar derivative, and occasionally cocaine or some other anodyne alkaloid, and secondly effervescent saline preparation of bromides, caffeine, phosphates, and some few contain also one or other of

the coal tar derivatives. The latter in most instances, physiologically incompatible, produce little trouble, except from the encouragement of pernicious habits, although, if used excessively, one or the other of the active ingredients may produce chronic and sometimes acute symptoms with death of the user. Several classic cases of acetanilid poisoning have been reported from the use of headache powders, and possibly some cases of sudden deaths from heart failure which could not be explained, may have been due to this habit, and we as custodians of health should safeguard the layman from these dangerous drugs.

CURES FOR THE ALCOHOL AND OTHER DRUG HABITS: The old fashioned substitutes for alcohol have already been considered, the modern extra-professional cures are chiefly carried on at institutions, and it is said that they depend principally on the use of strychnine and atropine as a stimulant, with the simultaneous injection or administration in other forms of apomorphine whenever liquor is allowed as a test, the patient soon becomes disgusted and is thus convinced that he or she is unable to tolerate alcohol in any form, various gums and sialagogues are employed to take the place of the local stimulation of tobacco, the inner bark of the tulip tree is used to a considerable degree, and is said to produce, in some unexplained way a distate for tobacco in any form: The successful treatment of any habit is to secure the patient's cooperation, and it is a question whether the need does not justify the means, at any rate it is absurd to suppose that the few cases of insanity which has developed in inmates of unethical institutions for the cure of drug habits, were due to the means employed, etc. When we consider the liability of these patients mental alienation, we must all agree that it is unfortunate that hospitals for the cure of drug habits cannot be established and conducted under the control of the regular medical profession.

CATHARTICS: Some of these are advertised as liver remedies, others are or were in vogue, also as headache cures, but the majority are simple cathartics, few contain mercurials, but are made up of the model of A. S. and B. (aloes strychnine and belladonna) pill with many modifications, many patients buy tablets primarially intended for physicians' prescriptions. The teas and powders are composed mainly of compound liquorice powder, senna and similar mild laxatives, of late years cascara has become the favorite laxative, both of the quack and the regular. Probably for occasional use most of the cathartics are allowable, but for any chronic state the utmost caution is necessary, and the use of atropine or any drug that has any constitutional effect is undesirable.

THE PATENT LINIMENTS, SALVES and PLASTERS: are in the most instances harmless, though, it must be borne in mind that there can be in some, the dangerous absorption of morphine, atropine and cantharides, etc. In the most instances they do very little or no good, hence should not be employed.

HAIR TONICS; DYES and BLEACHES: The older hair

tonics were diluted alcoholic solutions of quinine or some other supposedly local stimulant. The recent ones usually contain jaborandi. The dyes contain lead, silver, or cyanogen compounds, and may cause systemic poisoning, the effect on the hair is slowly toxic. Bleaches formally depended mainly upon borax and other alkalies: at present upon hydrogen peroxide, while systemically harmless, the hair loses its lustre and premature greyness results.

PAIN KILLERS: Those for external and sometimes internal use, contain an opiate, chloroform, a mydriatic or cardiac depressant anodyne. Those for local use, as dental wax, or gums, balms, etc. for application to the external surface depend upon the presence of aconite, veratrum, cocaine, gelsemium and other dangerously depressing drugs. Let us all do what we can to abandon their use.

GONORRHOEA CURES: Most of these, whether for internal use or use as injection or bougies are identical with those used by the regular physician, with the exception of a few of the former remedies, the danger of complications, especially from an injection sufficiently strong to warrant the claim of rapid cure are always paramount, and the laity do not guard against their occurence. There is also danger of self infection, especially of the eye, and infection of others, from relying upon a sweeping promise of cure. This needs no discussion.

MONTHLY REGULATORS: Practically all of these owe their sale to the desire to produce abortion, and if not, to an amenorrhoea due to tuberculosis, chlorosis, or other constitutional diseases, or to an intrinsic pelvic disease, which should require the most careful treatment. In the majority of cases we must consider first the toxic action of tansy, pennyroyal, parsley, ergot, etc., on the system at large, secondly the affect of aloin and the ordinary oxytoxics in producing pelvic congestion, thirdly the result in shock and danger of sepsis of the abortion itself.

LEUKORRHOEA INJECTIONS? SUPPOSITORIES, etc: These contain boric acid, tannic acid, alum, and zinc as such or in combination with some vegetable product as hydrastis and the like. Their local affect may influence the parts, but they seldom produce serious general symptoms.

SEXUAL TONICS: This group of nostrums, familiar to all through the "BEFORE and AFTER" illustrations usually contain phosphorus, damiana, strychnine, quinine, cantharides and the like, the danger from their use includes the direct toxic action and also the incentive to sexual excess.

LOCAL SEXUAL STIMULANTS: may consist of any simple ointment which may be applied with friction, or suction pumps for males to produce engorgement. All such measures are practically modes of masturbation.

INSTRUMENTS; INJECTIONS OR SUPPOSITORIES for the prevention of conception, exercise their greatest harm along moral lines, it must be admitted that they have had a beneficial effect in diminishing the frequency of interrupted coitus. The

chemicals employed to kill spermatazoa, may exert a toxic action, but even corrosive sublimate need not be sufficiently strong to cause appreciable absorption, unless used too often. The danger of these remedies is the production of endometritis and other pelvic troubles.

BUST DEVELOPERS: These are either mechanical suction devices, similar to brest pumps, or depend upon increasing the local blood supply by friction used in applying an ointment or lotion. They may possibly predispose to organic disease of the breast by traumatism.

These last few classes of quack medicines and applications, aside from their direct physical and moral dangers, are serving to educate the youth of the land in sexual matters from the meanest and most depraved standpoint. The illustrations connected with these advertisements are decidedly baneful to the morals of the youth, which we all know may be the starting point of a degenerate.

WORM MEDICINES: Are advertised very extensively and are given too freely by the laity and often unnecessarily. The intestinal parasites are by no means so common as is supposed by the mothers of our American youths. These preparations contain usually santonin in the form of a confection, and some contain besides this the various vegetable cathartics, a few contain calomel.

EYE WASHES; CATARACT CURES, etc., The former contain salt, zinc, boric acid and the like; lead and alum are somewhat dangerous, the milder astringents are merely irritating and not affective, hence are not used to any great extent. The greatest danger is that they are used for all classes of eye diseases, many of which may contra-indicate the use of the given preparation.

Cataract cures depend either upon the fictitious increase of vision by mydriatics, or upon counter-irration, as by the volatile oil of mustard. The constitutional danger in the former and the local danger with the latter treatment is obvious. Here may be mentioned the pumps intended to remedy refractive errors, by improving the shape of the eye ball, such instruments are very dangerous, by reason of the possibility of internal hemorrhage and retinal detachment, and are of course useless to effect a perminant correction.

Besides these I have mentioned we have the absolute frauds, as those proporting to be DRUGS, SOURCES OF OXYGEN, ELECTRICTY, VITAL ENERGY, ANTISEPTIC RADIATION OR WHAT NOT.

THE VALUE OF LABORATORY METHODS IN THE EARLY DIAGNOSIS OF GASTRIC CARCINOMA WITH REPORT OF TWENTY-SEVEN CASES.

By C. Urban Smith, Ph.G., M.D.

The early diagnosis of cancer of the stomach is of the utmost importance if we desire to give our patient the only hope of a

radical and complete cure through the medium of surgery; medical treatment up to the present time, is only symptomatic and palliative.

Recognizing these facts, one should indeed take advantage of any and all methods that will assist in establishing the diagnosis of an early case.

The 27 cases that I am about to report the laboratory findings, were cases that came under observation before it was possible to make out any growth or tumor by the ordinary physical methods of examination, and from the subjective and objective physical signs showed nothing positive of Carcinoma.

These cases were classified as early or beginning cancerous growths, for the reasons just mentioned, and subsequent developments.

It is impossible to give an accurate, or anything like an accurate, statement as to the length of time the neoplasm was present before examination, but one may obtain a fairly accurate knowledge of the age of the growth by its size and extensiveness, together with the clinical phenomena; of course one must not lose sight of the fact that certain forms of Carcinoma grow more rapidly than others.

The positive diagnosis of primary Carcinoma was verified in 21 cases as follows:

Nine cases by exploratory laparotomy, eight by subsequent developments, four by post mortem.

In the remaining six the diagnosis was only partially verified.

Two dying of intercurrent maladies before complete development.

Three by indefinite reports as to cause of death.

One case no subsequent record could be obtained, but fortunately this case was one of the most positive upon examination, and I feel that it is only fair to place it in the series.

Each case was examined repeatedly by the different tests, and no case was examined less than twice.

The analysis of the stomach contents of secretions and ferments was made from Ewald's test breakfast, consisting of two grammes of stale wheat bread and 300 C. C. of water, withdrawn an hour after eating.

Riegels oatmeal gruel administered on a fasting stomach in the morning after lavage the night before, was used for pathological amounts of lactic acid.

I have not compared these figures with other observers, and simply present as my own observations, in as brief a manner as possible.

In no case was there less than one positive test, and a number of the better marked cases showed three or four positive findings; much stress was laid upon the absence of hydrochloric acid as a positive diagnostic sign of Carcinoma immediately after Von den Velden's discovery in 1879, but less importance has been attached to the sign in later years.

It will be noted that the normal free acid in variable amounts,

and loosely combined, was found once at least after repeated examination in 19 cases or about 71%.

	Amount.	Positive or Negative.	Cases.	Per Ct.
Free Hcl	5° to 30°	Constantly positive	7	26
Hcl in excess or Hyperacidity	50° to 86°	Positive	4	14
Combined Hcl only		Positive	1	3.7
Hcl free and combined	None	Constantly negative	8	29
Hcl free	1° to 18°	Irregularly positive and negative	2	7
Hcl free	4° to 21°	Negative alternately with positive lactic acid	5	18
Pepsin and pepsmogin		Negative	5	18
Renin		Negative	4	14
Renin and zymogen		Negative	2	7
Total acidity	30° to 114°	Positive	27	100
Lactic acid, pathological amount	.5% or higher	Regularly positive	7	27
Lactic acid	.5% or higher	Alternating with disappearance of Hcl	6	22
Occult blood, stomach contents		Positive	9	40
Fæces (10 cases examined.)		Positive	6	60
Albumen, urine		Positive	6	22
Indican, urine	Variable	Positive	7	27
Yeast cells	Variable	Positive	18	66
Microscopic blood, stomach contents	Small	Positive	4	14
Sarcinæ	Large	Positive	1	3.7
Boas-Oppler bacillus	Variable	Positive	9	33
Cancer cells	Small	Positive	1	3.7
Red blood cells	3,200,000 to 6,000,000	Positive	27	100
Leucocytosis	14,000 to 22,000	Positive	6	22
Absence of digestive Leucocytosis	Less than 9,000	Positive	5	18
Gastric resorption by iodide potash test	Delayed beyond 20 minutes	Negative	9	33

The positive reaction of hydrochloric acid in such a large per cent. of cases would seem to indicate its absence of very little value, but when we consider that it was constantly negative in 28%, and associate this with its irregular absence, and presence of lactic acid in 22%, we may still feel that it is a sign of importance even in early cases.

If the generally accepted cause of the disappearance of hydrochloric acid, is atrophy and intirstitial change, it is natural to find hydrochloric acid positive, as we do not have these changes in beginning malignant growths, unless the growth has followed some chronic inflammatory disease of the mucosae. Hence the importance of the past history of the case.

Much reliance has been placed in the irregular absence of Hcl when associated with the presence of pathological amounts of lactic acid.

This phenomena was positive in 18% of the cases.

I do not attempt to explain this condition of intermittent inhibition of Hcl, but feel that it must be due to the action of either a toxin or some chemical compound upon the secretory glands.

One can readily explain the presence of the lactic acid when the antifermentative action of Hcl is removed.

The hyperchlorhydra cases are most misleading from the standpoint of the hydrochloric acid question and only confirms the

fact that the presence of the normal acid even in excess does not contraindicate the presence of cancer.

Ulcers or cicatrices habitually give a high Hcl degree when undergoing malignant change.

The 27% of cases with pathological amounts of lactic acid, nearly parallel the 29% of negative Hcl, and 18% irregularly positive.

Lactic acid in pathological amounts is only significant of bacterial fermentation of carbohydrates that has not been checked by the antifermentative action of Hcl.

It is only diagnostic by its association with negative Hydrochloric, and exclusion of Gastric stasis from benign obstruction, dilatation, etc.

Its presence, though, is a strong link in the chain of evidence.

Two of these cases in which pylorectomy was performed showed within sixty days after operation a return of 20° Hcl, and no pathological Lactic acid.

This is explained upon the ground of establishing good drainage, and removing focus of irritation, thereby giving the accompanying gastritis an opportunity to resolve.

It is evident that the glandular structure was not completely destroyed, and what remained, resumed function when the inflammatory process subsided.

The resorptive power of the stomach was delayed beyond the normal limit fifteen minutes in 33% of cases as determined by Penzolt's kalium iodide test.

The iodide was uniformily administered on an empty stomach as the time of appearance in the saliva and urine varies considerably whether digestion is at its height or at rest.

After Carcinoma is developed resorption is delayed, no doubt due to the accompanying catarrhal inflammation, but in early conditions unless associated with inflammatory states of greater or less degree, one cannot depend upon the test as suggestive of malignancy.

Iodide of potassium is frequently absorbed with ease in unfavorable pathological conditions, and is of unquestionable value when compared with food absorption.

Von Mering's experiments on dogs demonstrates that potassium iodide is absorbed in the intestines, and not in the stomach even after several hours.

If his experiments are confirmed, the drug is only valuable as a test for gastric motility.

Ten of the cases examined chemically for occult blood in the stomach contents, showed positive in 40%.

This recent test seems to be of considerable value, especially when we find it in both the stomach contents and faeces.

The faeces gave a positive reaction in 60%.

Whilst its presence in the faeces is not absolutely positive of Carcinoma, it is indeed most significant, provided the technique is carried out with care.

The preliminary preparation of the patient is of the utmost importance.

Some observers have reported over 70% of positive findings.

There are several pathological conditions of the stomach and intestines in which the blood may be positive, but by its constant presence and association with other signs, it is one of the most dependable laboratory reactions.

The gastric ferments, pepsin and pepsinogen were negative in 18%; renin, negative 14%; renin and zymogen, negative 7%.

Carcinoma has no more influence upon the absence of the ferments than upon the secretion of hydrochloric acid.

Their reduction or disappearance depends upon secondary gastritis or atrophy of the mucosae.

In well developed or late growths where secondary gastritis or atrophy is marked, the ferments are frequently negative, but in early cases unless preceded by disease of the mucosae, they are generally positive and of no value diagnostically.

Total acidity of the gastric contents bears no relation to carcinoma, only as far as indicating the degree of normal and abnormal acids.

The volatile fatty acids when positive are indicative of fermentation, often confirming the absence of Hcl and the condition of gastric ectasy.

Yeast cells in variable amounts were found in the aspirated test meals and wash water in 66%.

Pronounced yeast fermentation is not commonly found in cancer, and my observations lead me to conclude that larger quantities of yeast cells are more regularly found in early than later cases.

Sarcina ventriculi is rarely present in carcinoma and is more diagnostic by its absence than by its presence.

One case was positive.

The long thread-like bacillus known as the Boas-Oppler or lactic acid bacillus, was positive in 33%.

It is interesting to note that the per cent. of positive cases of the bacillus nearly parallels those of lactic acid.

This bacillus is very regularly found in stagnating stomach contents of carcinomatous cases, where conditions are favorable for the production of lactic acid.

It is occasionally found when Hcl is positive and associated with stasis.

Unless ectasy exists early in cancer, one is not likely to find the bacillus.

Slesinger and Kaufman have demonstrated that it has no specific importance, but when positive is very diagnostic of malignant disease.

Cancer cells demonstrated in the wash water of one case was very conclusive, and it is unfortunate that a sign of so positive value is rarely obtained.

The difficulty of demonstrating or obtaining a specimen showing a direct invasion of the glandular substance by epithelial cells, makes many observers claim the sign as worthless.

The red blood cells varied in count from 3,200,000 to 6,000,000 with proportionate amounts of hemoglobin.

There was nothing suggestive excepting a secondary anaemia.

Leucocytosis was positive in 22% cases, and nothing of value was demonstrated in differential counts.

Schneyer first called attention to the absence of digestive leucocytosis as diagnostic.

It was positive in 18% of the cases.

The author claimed the presence of digestive leucocytosis mitigated against cancer, but Stengel, Osler and others consider the sign of little value.

Albumen in the urine is generally transitory and of no special value.

Indican, in variable amounts was positive in 7 cases.

Senator laid considerable stress upon indicanuria as diagnostic of carcinoma, and no doubt is a fairly constant symptom in well developed cases, where proteid catabolism is more marked than in beginning growths.

A number of later laboratory tests were used in a few of these cases, but the number of examinations were not sufficient to draw conclusions.

Much has been said lately for and against the value of Soloman's residual albumen test.

My experience with the sign has been limited to 3 cases, with 2 positive results.

The value of this test as a positive sign depends upon its negativeness in other conditions.

CONCLUSION.

1. Repeated laboratory tests should be made in each and every case.

2. There is but one test that approaches the absolutely positive, the finding of cancer cells, but so difficult to obtain that the sign is of little use.

3. The most valuable early signs are the intermittent absence of hydrochloric acid with the presence of lactic acid; the constant absence of hydrochloric acid with the presence of lactic acid; positive occult blood in the stomach contents and feces.

4. Taking all the laboratory signs together, the greater the number of positive findings, the stronger the evidence in favor of malignancy; therefore one should take advantage of all methods offered.

5. When associated with the clinical phenomena, that is the history and physical signs, including the size, motility, position, etc. of the stomach, the laboratory methods become of inestimable value.

6. Our only hope of an early diagnosis is the forming of a chain of evidence by taking advantage of all clinical and laboratory methods, and excluding the possibility of other pathological conditions.

7. Explorotory laparotomy should be recommended in every suspicious case.

Correspondence.

THE STATE'S ATTORNEY REPLIES TO THE CRITICISMS BY THE EXAMINING BOARD.

Baltimore, October 21, 1907.

To the Editor of the Maryland Medical Journal,
Sir:

In your October issue you publish a paper read by Dr. Herbert Harlan, President of the Board of Medical Examiners, before the Medical and Chirurgical Faculty of Maryland, at a meeting held on board the steamship Charlotte, September 11th 1907.

The entire article is a criticism of me, as State's Attorney for the City of Baltimore, and of the Grand Jury, in so far as the enforcement of the Medical Laws are concerned, and, as from the beginning to the end, it is a tissue of mis-statements, I ask space in your valuable Journal to answer the same.

Dr. Harlan begins by telling of the efforts of the Committee of the Medical Society made in 1906 to enforce the law and says: "It may be mentioned that previous to this time the State Board had employed Detectives and had worked up, what seemed to them and to their attorney, strong cases against irregular practitioners.

"These cases were presented by the Grand Jury *but after a few days,* when there had been time enough for pressure to be brought to bear upon the Grand Jury and the State's Attorney's office, chiefly, I believe, in the way of misrepresentations of facts, the presentments were withdrawn." The answer to this is, that *it is simply* NOT TRUE. *I have never been before the Grand Jury in my life with reference to a case for violation of the Medical Law except to urge an Indictment.* When Dr. Harlan makes this statement, therefore, he not only states what is actually false but he states something that, at the time he made it, he could not have known whether it was true or false, for how could he know the confidential relations between the State's Attorney and the Grand Jury, which the facts show he did not know, but if he could know, he should be practicing clairvoyancy rather than medicine.

With reference to the case of Karl Klasius, I have this to say, it is my rule, when a case is brought to my office through the instrumentality of a Governmental Board, to dispose of the case in no way, other than by trial, without the previous authority of the Board presenting it. I cannot pursue a different course without hazard to the public welfare. After Klasius was indicted he came to me and stated that, if I would "stet" his case he would go out of the State and remain away. I called up Dr. Harlan and told him what Klasius had said and asked him what he wanted me to

do with reference to the case, his reply to me was, that if I really thought he would stay out of the State he considered such a disposition a proper one. In conformity therefore with this understanding I entered a "stet" in this case.

Dr. Harlan says that he did not so authorize me but, that on the contrary, he said he would not agree to it. I say, I acted in direct compliance with his instructions and I submit to any sensible man this query: Is it probable that I would act in opposition to the direction of a State Board with reference to a matter over which it had Statutory power? And I further submit that the final disposition of the sixteen Medical cases, to which Dr. Harlan refers in his article and to which I will immediately hereafter call attention, goes to prove my contention, as it shows that the action taken *in the case of Karl Klasius was along the general line of action adopted by Dr. Harlan with reference to all the cases.*

Now with reference to the sixteen cases, to which Dr. Harlan refers, I will say, that among the number indicted was a man by the name of Lingo. He employed, as his counsel, the Honorable Thomas G. Hayes. Mr. Hayes intended to raise the question of the constitutionality of the law by demurrer to the indictment and it was agreed that all of the other cases should await the result of the final determination of this case by the Courts. Several efforts were made to arrange a day for trial with Mr. Hayes and some, not unusual delay, was occasioned thereby. Finally a day was agreed upon for trial. As the case was a very important one I concluded to argue it myself and upon examining the indictment I had some doubt as to whether or not the indictment was sufficiently specific in its allegations, therefore, I determined, before trying the case, to secure a new indictment, which was done. This did not occasion, however, any appreciable delay.

When finally the case was up to be tried Mr. Hayes determined not to test the law, and, in my office, over my telephone, he, Mr. Hayes, arranged with Dr. Herbert Harlan, that, upon a plea of "guilty," Lingo should be fined Ten Dollars and costs and be permitted to take the examination required by law as a preliminary to the practice of medicine. This took place on the eleventh day of June 1907.

In the month of August (before the 15th), Dr. Harlan came to my office and made arrangements, satisfactory to him, with Mr. James A. Latane my assistant for the disposition of all the cases. Mr. Latane was subsequently taken with typhoid fever and when I heard of Dr. Harlan's criticism, I got from Mr. Latane's desk his memorandum of Dr. Harlan's directions. I called up Dr. Harlan, over the phone, and asked him if they were his directions and Dr. Harlan said they were.

In conformity with those directions but two of the cases were to be tried and the rest were to be "stetted," and I submit, *can Dr. Harlan justify the criticism he made of me when a month before he read his paper on board the steamship Charlotte he had, by his own action, practically settled all the cases but two about which*

he was complaining. According to his directions, all that I had to do, with the exception of the trial of two cases, was to confess "not guilty" in open Court as to one man and write the word, "stet," on certain conditions on the backs of the other indictments, and Dr. Harlan's only ground of criticism in this regard, when the matter is boiled down, is this, *that I did not write on the backs of the indictments what he wanted me to write at the moment he wanted me to write it;* though to have done so would in no manner have bettered conditions, because he would certainly have made just as good if not a better impression upon his audience on the Charlotte had he reported what he had accomplished, rather than erroneously led them to believe that by reason of my indifference he had failed in his work.

Dr. Harlan seems to have some general complaint about the Edelson case, the exact nature of which I cannot see, except that the Doctor concluded, as a matter of Law, that Edelson was practicing medicine unlawfully and that I did not convict him of that offense. I have no doubt that Dr. Harlan, in his specialty, is a very competent gentleman, I always thought him so, for he is the only occulist who ever treated me, but I really have the hardihood to believe that I know more Law than he does, and when I examined the facts of the Edelson case I concluded the evidence was not sufficient to convict on that charge, but as, upon false representations made to a woman that he was a physician, he had induced her to undergo a digital examination I concluded he was guilty of "assault," and, not feeling that I was compelled to consult with Dr. Harlan upon a legal proposition, without consulting with him, and of my own motion, I sent to the Grand Jury a special case against Edelson charging him with "assault," the result of which is Edelson is now serving a term of one year in Jail.

I now ask the members of the Medical profession whether or not in taking this step I did not accomplish more for the profession and the public than would have been the case had I tried Edelson for practicing medicine illegally.

Dr. Harlan further says, that inasmuch as a certain Dr. Richardson had loaned Edelson his name and his diploma to hang in Edelson's office that "High legal authority tells me (Dr. Harlan) that Richardson was guilty of conspiracy to defraud and could be indicted for that offense but the most we have been able to do is to get the State's Attorney to say he would 'look into the matter.'" I did look into the matter, as the result,—I did not proescute Dr. Richardson for conspiracy to defraud—and I do not hesitate to say, upon the facts of this case, as disclosed, that there is no high legal authority either in this State or the United States who will say that upon these facts it would be proper to indict Richardson for conspiracy to defraud, nor did the facts of the case warrant an Indictment under Section 105 of Article 43 of the Public General Laws. If, however, Dr. Harlan has evidence that Richardson

loaned Edelson his diploma to hang in his office, for the purpose of deceiving the public, Richardson was certainly guilty of "unprofessional or dishonorable conduct." In the course of the mighty efforts made by Dr. Harlan for the benefit of the profession and the public, may I ask, what steps did he take, as the President of the Board of Medical Examiners, or in any other capacity, to revoke Richardson's license, as provided for by Section 106 of Article 43 of the Public General Laws?

When Dr. Harlan makes his statement on page 401 that, "The latest statement from the State's Attorney's office is to the effect that the indictments as originally drawn were defective and all the cases will again have to go to the Grand Jury," he knew, or ought to have known, at the time he made it, that the new indictments were not intended in but two of the cases, and that the latest indictment was found on the fifteenth day of August, and therefore, Dr. Harlan's statement, with reference to this matter, was not in conformity with what he knew, or ought to have known, to be the facts of the case, and when he further refers to the possibility of trying some of the cases in the Fall, he knew it was not then expected to try but two of these cases and that according to his directions the others were to be disposed of as hereinbefore stated.

Dr. Harlan, in his paper, not only assumes the various roles of a State Officer, a Physician and a Lawyer, but also that of a Political Adviser, for, in conclusion, he advises the medical men to bear in mind what he chooses to call my indifference "to the interests of the general public and the medical profession," when I ask future favors at their hands. In reply to this, I wish to say, I have tried as best I knew how to be the State's Attorney for all the people and not to be the representative of any special class or profession but during my term I have come in contact with hundreds of medical men, and in various ways assisted them, and have been assisted by them in the enforcement of the Law; to all of them, who know me, I feel the charge of Dr. Harlan came as a distinct shock and, in conclusion, permit me to say that during my term of office, in the prosecution of Cocaine cases, Abortion cases, Assault cases, when the assault consisted of pretended physicians examining women, Health Ordinances, etc., I have done more for the benefit of the medical profession and the public than Dr. Harlan can ever hope to accomplish, if it be understood that when Dr. Harlan has nothing else to do and nothing better to say he is to entertain the public with unwarranted attacks upon the Public Officers, with whom he comes in contact, and this is greatly to be feared by them for the Doctor does not fail to take in the Grand Jury in his general denunciation.

Thanking you for the space you have given me in your Journal, I am, with great respect, Truly yours,

ALBERT S. J. OWENS.

DR. HARLAN'S REJOINDER.

My statements were specific about the State's Attorney; they did not reflect on the Grand Jury. The Grand Jury presented all the cases. Unless the Grand Jury was in error, indictments should have followed. Why does Mr. Owens declare, with such emphasis, that he "never went before the Grand Jury * * * except to urge an indictment?" No one intimated that he did. Why should Mr. Owens remind me of my inability to know just how and by whose intervention the Grand Jury found itself in error? I was "in front;" Mr. Owens was, or ought to have been, behind the scenes, and he knows, or ought to know, why the men presented were not indicted. I am not able to name anyone other than Mr. Owens as responsible for the poor results of our efforts to give effect to the medical-practice laws. Mr. Owens has a clear call to answer my criticism if he can.

Whoever cares to refer to my paper, printed in the October number of the JOURNAL, may see that Mr. Owens has not offered any substantial defense in any of the particulars there alleged, except to raise a question as to whether he had or had not my consent to stet the Klasius case. One cannot argue that point. Here is what the records show; note its chronology: The Police Department reported the Klasius case to the State's Attorney's office on May 20. Inquiry by the Examining Board under date of June 13 was not answered by the State's Attorney. Klasius appeared at the June examination, and the State's Attorney then inquired whether the Board would drop the prosecution in case Klasius passed. On July 3 the Board again inquired about the status of the Klasius case, and the State's Attorney replied on July 7 that Klasius had been indicted on June 1. Klasius failed at the June examination. In August the State's Attorney inquired whether the Klasius case might be stetted if Klasius would leave the State permanently. The State's Attorney says that I consented, with the understanding that Klasius would stay out of the State. If I consented, it is rather strange the stet was not entered about that time. In December Klasius appeared again for examination, failing again. On December 12 the State's Attorney stetted the case against Klasius on condition of his remaining out of the State.

It may be true, as the State's Attorney says, that the long delays and the high percentage of defective indictments occurring in our experience are not unusual in the State's Attorney's office. We are not objecting to these things because they are unusual, but because they are wrong and because they are avoidable, and because the State's Attorney, knowing that they are wrong and that they are avoidable, does not avoid them.

On several points Mr. Owens' statements are not accurate and his memory is bad. My paper was not a personal attack on Mr. Owens, but, as I say in the opening sentence, was to inform the Faculty "of what efforts had been made to prosecute unregistered practitioners of Baltimore city, to what extent the prosecution has been successful and where the fault lies for the imperfect success

of the efforts referred to." Toward the end of my paper I summarize as follows: "A great deal has been accomplished; 16 parties have been indicted, the most important of whom have left the State; one has plead guilty and has been fined and has pledged himself not to again practice without being registered; one was convicted of assault and is now in jail." The greater part of my paper, it is true, was taken up with a lot of facts that, to my mind, showed plainly that the State's Attorney's office was responsible for the unreasonable and unnecessary delay in the prosecution of the cases referred to.

I think for 11 cases to be indicted in October and the first result of these indictments to be the pleading guilty of one man on the 11th day of June, according to Mr. Owens' statement, was an unreasonable and unnecessary delay, and I am quite sure that that man would not have plead guilty at that time and paid the nominal fine imposed had it not been that he desired to be admitted to the June examination. The one case having been disposed of, it is true that I had a conference, by request, with Assistant State's Attorney Latane, and that we agreed that the best that could be done was to stet most of the cases that had been indicted by the October Grand Jury. One or two of them, however, it was agreed should be tried with the view of settling the question whether the mere hanging out of a doctor's sign was sufficient evidence upon which to convict. This conference, however, I think, took place in June, because I remember expressing the hope that something could be done with them before the summer recess of the courts. Mr. Latane replied to the effect that they would have to be indicted again and that it would be impossible to bring them up before the fall.

I do not know how much delay was necessary to secure the new indictments, but I do know that Mr. Owens gave it as a reason for one of the postponements in the Lingo case, and I feel that if the State's Attorney's office had not been indifferent or careless the indictments would have been drawn properly in the first place.

Mr. Owens' defective memory is well shown in what he says of the Edelson case. Edelson was not even prosecuted. Cohne was the man convicted, and Mr. Owens *told me* the reason the charge was changed from practicing medicine unlawfully to assault was because he could get a more severe sentence on a charge of assault than he could for practicing medicine unlawfully. He said nothing to me about any lack of sufficient evidence, but put it entirely upon the ground of being able to have Cohne more severely punished. I am satisfied that Cohne got no more than he deserved and he probably was guilty of a technical assault, but it is difficult for the non-legal mind to conceive of an assault with the consent of the party assaulted. This consent was given because the women believed Cohne was a doctor, and it looks to me

as if Mr. Owens, by having the man convicted on a charge that was purely a technical one, took the law into his own hands and administered a more severe punishment than the law inflicts for the practice of medicine.

In regard to the matter of Dr. Richardson, Mr. Owens' memory is again at fault. I first stated the case to him within a day or two of the Cohne trial, telling him plainly what had been testified to before the magistrate. He listened patiently and politely and promised to look into the matter. Mr. Latane did the same separately. Some four or five weeks later in Mr. Owens' office I asked him about the matter and he again promised to look into it, and stated that it was the first time that the case had been called to his attention, and went so far as to write Richardson's name on an old envelope lying on his desk, which I had a feeling was likely to find its way into his waste basket before I had gotten far from the courthouse.

I do not know when he looked into the matter, but I do know that he did not tell me on my statement that there was no conspiracy to defraud, and I do know, further, that the first time he manifested any interest in the case was after he had read my article in the MARYLAND MEDICAL JOURNAL. The Board did not revoke Richardson's license for the reason that Richardson never received a license. He was practicing before most of the members of the Board were born, and if Mr. Owens was as familiar with the law as he might well be he should know that the Board has no such power.

My experience with the State's Attorney's office was not such as to make me consider a case settled and disposed of when I had talked over the matter with the assistant State's Attorney. My statement was that not one of the cases had been tried. I did not say that no steps had been taken toward the disposal of them, and I feel that, as the court records show, the cases of Creevey, Gault, Green, McCurdy, Cromwell, Gannaway, Abbott, Adler and Taylor were disposed of only on September 30, and that the cases of Darrah, Crowley, Dominic Romeo and Pasquale Romeo were at that time set for trial on October 8. I was entirely justified in saying that no case had been tried.

To my mind the publicity given about the middle of September to the way the State's Attorney's office had been dealing with these medical cases up to that time produced more activity in that office and more results in three weeks than our utmost efforts had been able to accomplish in many months, and therewith, for the present, I am content. It was entirely accidental that the meeting of the Faculty took place just before a Democratic primary. That one newspaper should refer in large headlines to my paper, rather than to other important professional papers that were read, and that Mr. Owens' political opponents should freely advertise the matter was possibly Mr. Owens' misfortune, but was in no way my fault.

MARYLAND MEDICAL JOURNAL

JOHN S. FULTON, M.D., *Editor*

Associate Editors:

THOMAS R. BROWN, M.D. | HUGH H. YOUNG, M.D.
ROBERT REULING, M.D. | JOSE L. HIRSH, M.D.

HORACE M. SIMMONS, M.D.,
Secretary-Treasurer and General Manager.

BALTIMORE, NOVEMBER, 1907

AN INTERESTED LETTER.

SOME friends have referred to the editor of MARYLAND MEDICAL JOURNAL the interesting letter which is printed below. Since the samples received are identical in appearance, this letter was probably multigraphed in numbers and distributed widely. The specimen furnished by Dr. Williams is chosen for publication because Dr. Williams sent it for that purpose, and because the JOURNAL is unwilling to allow Dr. Williams more than half the credit of the wider, and wider-open, publicity which the subject deserves:

"Overlook," Blue Ridge Summit, Pa., October 5, 1907.

Dr. J. Whitridge Williams,
Baltimore:

My Dear Doctor—I will promptly pay you 15 per cent. of all amounts paid me by any patient or friend you may send to my lovely private home, "Overlook," at Blue Ridge Summit, Pa., for rest, recuperation or healthful enjoyment. The best times for real improvement are in the fall, up to Christmas, and in the spring.

I will "assist" you in carrying out any special measures desirable. No danger of my "taking the patient," as I am not, and do not wish to be, in active general practice. My object is to apply the immense benefits of this magnificent climate, in conjunction with all the helps afforded by a real private family life, in a beautiful, artistic, comfortable and well-equipped home, looking after each guest's individual needs, as the case demands.

We can accommodate from six to a dozen, according as one or two occupy a room. Terms from $15 to $25 per week.

"Overlook" stands on a fine promontory, a short walk from the station—the very finest situation and most magnificent views in all this mountain region. Purest water on all floors; well heated and furnished in every way. No such place as beautiful "Overlook" can be found within 100 miles of Baltimore. Finest train service; about two hours from Union Station.

No objectionable cases taken; nothing in the least contagious or infectious. Splendid for surgical convalescents, nervously "run down" people, weak people, folks with poor digestion, and anyone at all who wishes to enjoy this magnificent situation and healthful life, even if there is no special sickness or weakness to combat.

Send patients or guests now, Doctor, in this glorious fall weather, when the leaves are turning. It is simply grand.

Cordially yours,

DR. R. K. CARTER,
Blue Ridge Summit, Pa.

IS CHUMMING LAWFUL IN MARYLAND WATERS?

IT is necessary to define the word "chumming" for the benefit of unsophisticated sportsmen who have never considered such a proposition as this. The practice of chumming is most uncommon in Maryland. For a consideration, the market fishermen at Ocean City will take a greenhorn three or four miles out to sea to chum for bluefish. The tackle includes only handlines, each having two or more hooks, and any kind of a lure, or no lure. The essential device is a rotary meatchopper, which grinds out into the sea quantities of minced squid, or menhaden, or other inferior

grub. Through a wake of this trash you troll your handline while many good fish get cheap refreshment, and not a few get the hook. Two men fishing with handlines, while one man grinds chum, may load a small boat in a few hours. Only market fishermen treat the gamey bluefish in this discourteous way. A very brazen amateur may have taken a fish or two in this ignoble fashion, but he will hardly confess it to a thirty-third degree angler.

There are no conditions under which chumming is admirable, but under certain conditions the practice is excusable. Since we are submitting this novel proposition to all the readers of the JOURNAL, it seems advisable to state these conditions. They are quite unusual.

If you have no decent tackle, nor any means of procuring decent tackle, and if fisherman's pride be driven clean out of you by hunger and cold and nakedness, and if you have but two friends and they are in like extremity, and if your joint poverties can assemble a boat, a line or two, a chum-chopper and a basket of murrain alewives, then get aboard, go about your miserable business, and may the beautiful sea minister to your needs without regard to your merits.

A PULLMAN BEVERAGE.

THIS story begins, or ought to begin, in the Division of Foods, Bureau of Chemistry, United States Department of Agriculture, Washington, D. C. Starting from this locality, you must go to the Pennsylvania Depot and board any Philadelphia express which carries a Pullman buffet car. You must order a light luncheon, including coffee, if you are after the particular sensation about to be described. When ordering coffee you need not make any qualifying gesture or secret sign, for the waiter will interpret your order. I know a man who really wanted coffee, and what happened to him may happen to you, as follows:

When you order your luncheon the train is in the District of Columbia. When it is served you have run 30 miles into Maryland. Its accompanying beverage is hot, clear and brown, but lacks odor. If you are disappointed in the absence of coffee odor, it serves you right, for the substance which we are describing is not the kind of coffee to which you are accustomed. It was for the sake of an unusual experience that you were advised to order coffee. You will taste the pretty infusion, and then, remembering how coffee would taste if you had it, you will grow unreasonable. You will tell the waiter that you wanted real coffee, which is not quite true, my boy. He assures you that he knew you wanted your coffee right and he did his best, making it half as strong again. Having fibbed about your original order, you go deeper, and say that there is no coffee in the cup. You assert that there is no coffee at all in the car. The waiter says that he will show it to you, and agrees to bring it to you in the smoking-room. While you are crossing the Susquehanna he brings you a Mason fruit jar containing a fine brown powder. He says that it is coffee, but its appearance is against that statement. You open the jar and inhale deeply. It is possible to distinguish a faint odor of coffee. At a hundred a day and expenses an expert would swear to the odor.

The jar carries a white label which says in bold black type, "Pullman Coffee," and then gives instructions for making the infusion. Things go too fast in your head, and you tell the waiter that you will prove that the substance is not coffee if he will bring you a glass of water. He brings it—ice water. You say that coffee is oily and hard to wet, and will not stain cold water nor sink, while the common coffee substitutes and adulterants

give a brown color to cold water, are easily moistened and will sink in a little while. Then you drop some of the powder on the surface of the water, and the waiter watches in dumb interest while a brown color creeps below the floating powder, and presently small masses detach themselves and sink slowly to the bottom of the tumbler. Then the waiter says that he will strike the coffee off your check, for he will not serve a gentleman any kind of food or drink which he knows is not right. You have shocked the faithful soul, though your experiment proved nothing, unless it is a fact that no coffee will behave in this unusual way. It is, however, an interesting brew, this that you ordered in the District, discarded in Maryland and paid for in Delaware. Perhaps Pullman coffee, the buffet variety, is a miracle astray from Luther Burbank's wonder garden.

THE INTERNATIONAL CONGRESS ON TUBERCULOSIS—WASHINGTON, 1908.

THE preliminary announcement of the International Congress on Tuberculosis is now being distributed and is attracting the attention of the secular as well as of the medical press. The announcement is printed in four languages—German, French, Spanish and English. Heretofore Spanish has not been one of the official languages of the International Congress, but the American committee has made it one of the official languages in recognition of the importance of that tongue, not only in the politics of the Western Hemisphere, but also in the history of scientific and humane effort toward the control of tuberculosis.

The preliminary announcement shows the formation of special committees in 46 countries besides our own. In the United States the plan of organization seems to promise political recognition of this congress in all parts of the country. Seven of the nine Federal Departments have signified their intention to participate, and a majority of the State Governments have taken steps to be officially represented. Twenty-three Governors of States, it is said, have already given their official auspices to the congress by directing departments of State Government to prepare for the event.

The congress will be divided into seven sections, and these will hold their sessions during the last week of October. The proceedings will last three weeks, for, besides the scientific sessions, there is to be a great exhibition and a course of special lectures, open to the general public and given by distinguished visitors from abroad. Among those who have signified their intention to attend the congress and deliver such lectures are Emil von Behring or Marburg, R. W. Philip of Edinburgh, G. Pannwitz of Berlin, Arthur Newsholme of Brighton, England; Theodore Williams of London, S. Kitasato of Tokyo, J. H. Spronck of Utrecht, Karl Turban of Davos-Platz, A. Calmette of Lille and Maurice Letulle of Paris.

This event will be of most exceptional interest to the medical profession of the United States, for this congress meets but once in three years, has never met in America before, and is not likely to meet again in the United States for many years to come. Meeting in Washington, in the autumn of 1908, this congress will prove very attractive to Marylanders. There are two classes of members—active members, who pay a fee of $5 and have all the privileges and benefits of the congress, including a set of the published transactions, and associate members, who pay a fee of $2 and will not receive the publications nor have the right to participate in the discussions. The general offices are in the Colorado Building, Washington, where a considerable office force is devoted wholly to preparation for this most interesting event.

Medical Items.

BALTIMORE.

We are obliged to republish the results of the last State examinations for license to practice medicine. As printed last month, the statement was so erroneous that an acknowledgment of particular errors would take more space than a republication of the entire statement. It is just one more example of the treachery of figures. A misprinted word may lose the sense of a sentence or of a paragraph, but a printer who allows a slight disarray to occur in a numerical statement may do better to pi the whole page and begin again.

The Herter lectures before the medical department of the Johns Hopkins University will be given this session by Edward A. Schäfer, LL.D., F.R.S., professor of physiology in the University of Edinburgh, at the end of April, 1908.

GENERAL.

Cigars are now made in Germany which are free from the danger of transmitting infectious diseases from the workman to the smoker through the practice of gumming the wrapper. In the new method the wrapper is held in position by a tinfoil ring, removable before smoking.

The physician in attendance during the last illness of a wealthy Chicago woman, who died several years ago in California, has been awarded a verdict against the estate for $100,000 for professional services. The claim was made by virtue of a contract made with the patient that he should attend her until the time of her death, and should then receive $100,000 by her will. The physician had given all his time to the patient during several years, and the jury allowed the full amount sued for.

The hospital of the University of Pennsylvania was recently closed by order of the Philadelphia Bureau of Health by reason of the admission to the wards of a sailor from an incoming vessel, who was subsequently found to be suffering from smallpox. Every person within the hospital was vaccinated, and none was permitted to make his exit and none permitted to enter until the period of incubation had elapsed and the hospital had been disinfected.

According to *Science*, a committee has been formed in Germany, with the Prussian Minister of State as chairman, to found an institution in honor of Dr. Robert Koch. It is intended that the institution shall be devoted to research into the means of checking the diffusion of tuberculosis and that it shall be a permanent memorial of the discovery of the tubercle bacillus by Professor Koch 25 years ago. Appeal is made for contributions sufficient to make the institution a tribute of gratitude to Koch, similar to those with which the name of Pasteur has been honored in France and that of Lister in England.

The London correspondent of the *Journal of the American Medical Association* tells the following interesting story: A peculiar position has arisen at Southend, the nearest seaside resort to London, situated on the estuary of the Thames. Dr. Nash, the health officer, distinguished himself for zeal in the discharge of his duties and incurred the enmity of some members of the Town Council because he condemned the insanitary condition of their premises—a by no means unusual fate of health officers. The Council, therefore, as a preliminary to getting rid of him, when the three years of his appointment was about to terminate, resolved to reappoint him for one year only at a reduced salary. The doctor refused to accept the appointment under these conditions, and it was advertised as vacant in the medical journals. But the Council soon found themselves in a difficulty. The glaring injustice of their treatment aroused the severest censure in the *Lancet* and *British Medical Journal* and in the presidential address of Sir James Crichton Browne at the annual meeting of the Sanitary Inspectors' Association. The result was a professional boycott, and there was only a solitary applicant for the vacant appointment. Moreover, the sanitary reputation of the town—the Mecca of hundreds of thousands of Londoners in search of health—has suffered in consequence of the scandal. Indeed, the council, in its attacks on the doctor, only too well produced, helped in the depreciation of the town. One of the charges made against him was that he had done Southend harm by declaring that he would not bathe off the beach for $5000, because of the sewage there. Southend is now faced with the prospect of being without a health officer when Dr. Nash's term expires. In disgust, his principal opponent said at the Council meeting that "the doctors deserve to be congratulated on the strength of their trades-unionism."

NOTICE **Corrected publication of results of June, 1907, Examination held by the Board of Medical Examiners of Maryland.**

The Summary of results of the Examination held by the Board of Medical Examiners of Maryland in June, 1907, is herewith republished, owing to errors in the arrangement of numbers having occurred in the Summary as published in the September number of this Journal.

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, June 18, 19, 20 and 21, 1907.

No.	College of Graduation.	Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Materia Medica	Therapeutics	Physiology	Total	Average
1	Leonard Medical, '05	..	....	58	....	64	37	53	75	54	....	....
2	Johns Hopkins, '07	81	100	73	90	78	66	92	84	90	754	84
3	George Washington University, '06	..	....	45	....	....	45	50	73	....	....	....
4	Medical Chir., Philadelphia, '03	85	85	44	90	75	57	75	89	75	675	75
5	Leonard Medical, '07	76	85	64	85	75	43	78	62	75	643	71
6	University of Maryland, '07	91	90	80	100	87	85	76	75	92	776	86
7	University of South, '06	60	....	....	....	....	52	78	82	61	....	....
8	Woman's Medical, Baltimore, '07	91	95	92	90	82	37	86	88	75	736	82
9	University of Maryland, '07	94	100	81	100	82	82	81	93	93	806	90
10	Maryland Medical '05	..	....	....	....	75	75	....	....	75	....	....
11	George Washington University, '06	93	80	90	87	82	89	79	87	75	762	85
12	Maryland Medical, '07	65	75	35	75	69	56	87	70	60	592	66
13	Maryland Medical '07	76	85	52	75	75	45	77	75	75	635	71
14	Baltimore Medical, '07	77	80	76	90	70	20	68	80	77	638	71
15	University of Maryland	91	....	....	....	....	90	91	....	90	....	....
16	Woman's Medical, Pa., '07	81	75	75	100	86	68	75	92	91	743	83
17	University of Maryland	86	....	....	....	....	86	82	....	85	....	....
18	Meharry Medical, '07	47	75	12	80	48	13	48	65	65	453	50
19	Meharry Medical, '07	60	75	22	80	45	33	42	62	75	494	55
20	George Washington University, '07	86	75	65	75	75	58	62	73	76	645	72
21	Woman's Medical, Baltimore, '07	70	90	69	95	83	49	93	88	75	712	79
22	Medical Chir., Philadelphia, '07	80	90	82	95	89	86	92	92	90	796	88
23	University of Maryland	87	....	....	....	....	83	95	....	95	....	....
24	University of Maryland	88	....	85	....	....	90	80	....	95	....	....
25	College of Physicians and Surgeons, Balto., '07	78	85	70	85	84	86	77	72	80	717	80
26	Baltimore Medical	84	....	....	....	....	83	73	....	91	....	....
27	University of Maryland, '07	79	85	92	75	80	75	84	92	75	737	82
28	University of Maryland, '07	81	85	77	100	81	89	83	89	95	780	87
29	University of Maryland, '06	62	90	76	80	77	73	84	93	90	725	81
30	University of Maryland, '07	55	85	61	90	75	75	82	87	85	695	77
31	University of Maryland	85	....	....	....	....	82	90	...	70	....	....
32	Woman's Medical, Baltimore, '07	85	80	79	85	71	76	75	85	82	718	80
33	Woman's Medical, '06	81	80	75	75	79	75	75	86	70	696	77
34	University of Maryland, '07	86	85	75	85	76	77	77	87	75	723	80
35	University of Maryland, '05	81	90	76	80	76	75	95	95	92	760	85
36	University of Maryland, '07	89	90	82	100	67	76	78	90	95	767	85
37	Johns Hopkins	77	....	....	....	....	56	90	93	85	....	....
38	College of Physicians and Surgeons, Balto., '07	85	85	71	85	84	78	78	88	71	725	81
39	University of Maryland, '07	37	85	68	85	75	50	77	77	80	634	70
40	Harvard Medical, '07	60	85	72	95	81	77	83	78	68	699	78
41	University of Maryland, '05	75	....	....	....	....	53	....	....	....	....	....
42	Yale Medical, '06	79	90	68	90	75	50	82	82	80	696	77
43	Baltimore Medical, '07	70	98	61	90	75	58	62	49	70	633	70
44	University of Maryland, '07	76	90	72	85	80	85	82	81	85	736	82
45	Baltimore University	91	....	....	....	....	93	87	....	90	....	....
46	University of South, '04	43	....	29	....	....	....	....	....	....	....	....
47	Baltimore Medical, '07	78	80	79	90	76	77	83	75	75	713	79

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, June 18, 19, 20 and 21, 1907—(*Continued.*)

No.	College of Graduation.	Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Materia Medica	Therapeutics	Physiology	Total	Average
48	University of Maryland, '07	82	98	75	90	69	89	95	75	80	753	84
49	Baltimore Medical, '07	78	85	67	90	56	64	90	82	85	697	77
50	College of Physicians and Surgeons, Balto., '07	80	100	82	100	93	85	88	92	76	796	88
51	Jefferson Medical, '06	67	90	46	100	62	49	80	76	80	650	72
52	University of Maryland, '07	69	85	55	100	75	37	80	61	60	622	69
54	Baltimore Medical, '07	82	85	....	100	79	77	75	77	80	655	73
55	University of Maryland, '07	83	85	70	100	75	75	....	73	60	621	69
56	University of Maryland	90	....	....	....	....	95	85	....	75	....	....
57	University of Maryland, '07	85	90	70	100	72	16	83	84	75	675	75
58	University of Maryland	84	....	....	....	....	70	86	....	70	....	....
59	Woman's Medical, Baltimore, '07	61	90	50	85	75	47	80	75	75	638	71
60	Woman's Medical, Baltimore, '07	85	90	75	90	88	39	87	80	65	699	78
61	College of Physicians and Surgeons, Balto., '06	84	95	75	100	87	73	75	85	75	749	83
62	Baltimore Medical, '07	88	90	68	80	75	63	72	68	75	679	75
64	University of Maryland, '07	..	....	....	....	....	54	....	....	....	....	....
65	Baltimore Medical, '07	52	90	66	75	64	49	58	52	60	566	63
66	University of Maryland, '07	67	95	82	100	78	82	94	93	63	754	84
67	University of Maryland, '07	75	90	90	95	76	52	82	75	78	713	79
68	Baltimore Medical, '07	42	50	32	75	45	48	88	90	50	520	58
69	University of Maryland, '07	81	95	81	80	75	71	80	94	90	747	83
70	University of Georgetown, '05	75	80	65	75	84	72	85	78	75	689	77
71	University of Maryland	75	....	....	....	....	64	76	....	75	....	....
72	University of Maryland, '07	67	95	48	80	63	39	77	50	85	604	67
73	University of Maryland, '07	78	85	73	100	79	80	60	82	70	707	79
74	University of Maryland	89	....	....	....	....	87	90	....	95	....	....
75	University of Pennsylvania, '07	64	90	71	85	75	50	75	80	85	675	75
76	University of Pennsylvania, '07	82	90	85	85	94	75	80	75	95	761	85
77	University of Pennsylvania, '07	86	95	78	90	85	71	80	91	90	766	85
78	University of Pennsylvania, '07	89	98	93	95	90	58	87	86	85	781	87
79	Maryland Medical, '06	63	80	31	90	75	40	77	75	85	616	68
80	Georgetown University, '07	89	95	87	100	77	79	92	83	65	767	85
81	George Washington University, '07	88	95	66	95	87	78	85	80	60	734	82
82	Baltimore Medical, '04	76	80	60	90	77	31	77	62	65	618	69
83	University of Maryland	68	....	....	....	....	61	90	....	84	....	....
84	Baltimore Medical, '07	82	90	86	95	82	81	93	80	96	785	87
85	Baltimore Medical, '07	86	95	75	90	79	76	92	85	80	758	84
86	University of Maryland, '07	86	80	75	90	82	75	80	85	75	728	81
87	University of Maryland, '07	50	80	45	85	72	79	77	68	60	616	68
88	Georgetown University, '06	88	98	86	85	87	89	97	93	95	818	91
89	University of Maryland, '07	76	95	83	100	80	88	90	92	75	779	87
90	University of Maryland, '07	78	85	77	80	71	83	93	84	75	726	81
91	University of Pennsylvania, '07	88	95	80	90	89	67	82	83	80	754	84
92	University of Pennsylvania, '07	85	100	88	95	82	78	93	89	95	805	89
93	Baltimore Medical, '03	43	...	10	....	60	18	....	....	60	....	....
94	College of Physicians and Surgeons, Balto., '07	83	90	69	100	75	68	81	82	85	733	81
95	University of Maryland, '07	75	90	35	90	66	62	78	75	85	656	73
96	University of Maryland, '05	..	....	39	....	....	50	....	....	....	....	....
97	University of Maryland, '07	88	95	80	100	82	53	78	85	96	757	84
98	Maryland Medical, '05	48	....	32	....	54	28	....	....	....	....	....
99	University of Maryland, '07	94	90	82	100	75	90	88	67	84	770	86
100	University of Maryland, '07	89	90	88	95	89	93	97	92	95	828	92
101	University of Maryland, '07	71	90	75	90	84	40	78	87	60	675	75
102	Maryland Medical, '07	80	90	32	85	80	20	83	63	54	587	65
103	Maryland Medical, '07	38	75	49	100	68	23	78	64	58	553	61
104	University of Maryland	56	....	....	....	....	35	63	....	54	....	....
105	University of Maryland, '07	77	85	77	90	75	30	82	84	75	675	75
106	Johns Hopkins, '07	92	95	69	80	81	78	88	85	86	754	84
107	Johns Hopkins, '07	90	80	96	65	82	96	83	91	86	769	85
108	Maryland Medical, '07	8	30	5	80	48	13	68	31	46	329	37
109	Johns Hopkins, '07	80	90	91	95	78	79	85	82	79	759	84
110	Johns Hopkins, '07	72	90	84	100	83	83	82	76	70	740	82

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, June 18, 19, 20 and 21, 1907—(*Continued.*)

No.	College of Graduation.	Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Materia Medica	Therapeutics	Physiology	Total	Average
111	Johns Hopkins, '07	91	95	89	100	84	83	95	88	91	816	91
112	Johns Hopkins, '05	85	95	88	100	75	80	96	94	83	796	88
113	Johns Hopkins, '07	..	....	....	....	....	....	....	....	....	....	...
114	Johns Hopkins, '07	83	90	85	90	75	63	86	84	82	738	82
115	Johns Hopkins, '07	91	100	83	75	90	78	84	78	68	742	82
116	Johns Hopkins, '07	87	95	89	95	82	75	77	93	77	770	86
117	Johns Hopkins, '07	81	95	81	85	80	84	87	....	85	678	75
118	Johns Hopkins, '07	77	90	67	75	85	40	75	53	84	646	72
119	Johns Hopkins, '07	82	95	83	100	79	86	80	90	82	777	86
120	University of Maryland, '07	88	95	75	80	87	82	90	80	87	764	85
121	Maryland Medical, '05	27	90	11	75	63	43	92	83	63	547	61
122	Johns Hopkins, '07	87	95	92	85	91	88	80	87	73	778	86
123	Johns Hopkins, '07	94	90	93	100	93	84	80	92	87	813	90
124	Johns Hopkins, '07	81	95	87	95	85	92	88	94	90	807	90
125	Johns Hopkins, '07	64	98	91	100	90	66	97	76	86	768	85
126	Maryland Medical, '06	70	....	42	....	....	55	....	....	....	....	....
127	Johns Hopkins, '07	81	85	73	95	83	63	88	93	82	743	83
128	Johns Hopkins, '07	93	95	97	100	88	98	81	93	87	832	91
129	Johns Hopkins, '07	81	85	75	85	85	75	89	82	76	733	81
130	Johns Hopkins, '07	92	90	97	85	95	92	78	87	92	808	90
131	Johns Hopkins, '07	78	90	86	95	93	89	87	80	69	767	85
132	Baltimore Medical, '07	85	85	59	95	76	83	82	66	80	711	79
133	Maryland Medical, '05	..	....	50	....	....	....	....	....	....	....	....
134	Baltimore Medical, '06	72	85	63	75	75	61	94	85	70	680	76
135	University of Maryland, '07	..	....	....	....	....	....	....	....	....	....	....
136	Johns Hopkins	60	....	....	....	....	57	92	81	87	....	....
137	University of Maryland, '06	..	....	41	....	....	47	....	....	70	....	....
138	Baltimore University, '02	12	60	0	75	16	4	77	53	60	357	40
139	University of Maryland, '07	77	98	90	90	86	76	93	87	88	785	87
140	Johns Hopkins	62	....	....	....	....	62	87	78	88	....	....
141	Baltimore Medical, '07	42	85	31	90	64	26	90	92	66	586	65
142	Baltimore Medical, '07	60	90	66	85	75	65	93	90	75	699	78
143	Baltimore Medical, '07	80	90	81	75	80	75	95	93	86	755	84
144	University of Maryland, '07	80	85	86	95	75	70	78	75	67	711	79
145	Baltimore Medical, '05	..	....	33	....	....	56	....	58	....	....	....
146	University of Maryland, '07	85	95	69	85	83	50	95	93	70	725	81
147	Maryland Medical, '05	40	....	36	....	....	60	....	....	....	....	....
148	College of Physicians and Surgeons, Balto., '06	89	90	75	90	82	47	93	85	72	723	80
149	Howard University, '03	37	75	12	80	36	41	96	81	66	524	58
150	College of Physicians and Surgeons, Balto., '07	66	90	79	90	77	57	66	93	67	685	76
151	Johns Hopkins, '07	85	85	90	95	85	93	78	95	78	784	87
152	University of Pennsylvania	89	....	....	....	....	78	60	....	72	....	....
153	University of Maryland	87	....	....	....	....	76	95	....	81	....	....
154	Maryland Medical, '05	40	50	33	....	55	11	57	30	....	....	....
155	Johns Hopkins, '07	75	85	97	90	88	81	75	81	81	753	84
156	College of Physicians and Surgeons, N. Y., '07	92	95	68	65	84	22	75	77	75	653	73
157	University of Maryland, '07	33	....	....	....	....	37	....	...	....	....	....
159	College of Physicians and Surgeons, Balto., '07	80	80	67	95	76	60	83	63	80	684	76
160	Johns Hopkins, '03	85	98	87	100	79	98	97	100	91	835	93
161	Maryland Medical	..	....	52	....	....	40	....	....	....	....	....
162	Baltimore Medical, '06	..	75	40	....	....	52	....	62	50	....	....
163	Ohio Medical, '03	75	....	35	....	....	34	....	....	....	....	....
164	Jefferson Medical, '07	55	80	65	90	78	42	96	94	75	675	75
165	Jefferson Medical, '07	67	80	51	90	79	20	87	85	60	619	69

In the above summary an average of 75 is required of those participating in the examination for the first time in order to secure a license. Those who have failed are eligible to re-examination at the the expiration of six months. They are then obliged to receive a rating of 75 in each branch in which they are re-examined before license can be issued. Under the Maryland laws, students who at the end of their second year have successfully passed their college examination in Anatomy, Chemistry, Materia Medica and Physiology are entitled to examination by the Board of Medical Examiners in these branches. The ratings made by these students in the examination known as the "second year examination" are carried forward and made a part of the final examination, when an average of 75 must be obtained to secure a license.

We trust that this statement will make clear the apparently incomplete examination of certain participants.

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REPORT OF THE MARYLAND STATE SANITARIUM.

By H. Warren Buckler.

READ BEFORE THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, APRIL 24, 1907.

THE Maryland Legislature, at the session of 1906, passed a bill introduced by Senator Moore, appropriating the sum of one hundred thousand dollars for the purpose of building, within the limits of the State, a hospital for the care of those of her citizens suffering from tuberculosis. In view of the fact that the establishment of such an institution is of vital interest to every practising physician in the State, it would seem quite right that the first report of the work thus far done towards building the hospital should be made to the members of this Faculty.

The bill authorizing the construction of the hospital further stated, that the selection of the site, the character of the buildings erected and the ultimate management of the institution should be left entirely in the hands of a board of nine directors, six of whom were to be appointed by the Governor, and the remaining three to be the members of the Board of Public Works, which consists of the Governor, Comptroller and State Treasurer. Governor Warfield, after consultation with the former Tuberculosis Commission, and with several gentlemen interested in the subject, decided to appoint medical men only to the board, with the exception of Ex-Governor John Walter Smith, who had always taken a deep interest in the welfare of the consumptive, and who must be regarded as the founder of the movement to establish a State institution in Maryland for tuberculosis.

Governor Warfield thought that, as far as possible, all sections of the State should be represented on the board, so accordingly he appointed Dr. Guy Steele, of Cambridge, Dr. Charles M. Ellis,

of Elkton, Dr. Charles M. Conley, of Frederick and Dr. Henry Barton Jacobs and myself, from Baltimore City.

The Board immediately organized, electing Ex-Governor Smith as President, who appointed a committee to secure a suitable site, and also a committee to consider the scope and plan of the new institution.

The Site Committee adopted the recommendations of the former Tuberculosis Commission, viz:—that the site should be at an elevation of at least 1000 feet; that it should be in immediate vicinity to a railroad, to insure economical hauling of supplies, patients, etc.; that it should have a southerly or south-easterly exposure, with proper wind protection from the north, and that there should be an unlimited water supply on the property, or nearby.

After inspecting sites in all sections of the State, the Committee finally decided to purchase a piece of property near Sabillasville, Frederick County, in the heart of the Blue Ridge Mountains, at an elevation of 1450 feet, overlooking the beautiful Hanover and Gettysburg Valleys, and immediately adjacent to the Western Maryland Railroad. I personally travelled from one end of the State to the other inspecting sites that had been offered to us, and I do not feel that I am exaggerating when I say that I think the Directors have chosen one of the most beautiful spots in the State for their purpose, and one that will compare favorably with the site of any other existing sanitarium east of the Mississippi River. In fact, I know of no institution, state or private, that will have so many geographical and climatic advantages as will the Maryland State Sanitarium. We have the desired altitude in a section remarkably free from moisture, where the summers are cool and bracing and the winters not unendurably cold, and best of all, within a few hours steaming distance of all our chief centres of population. The Directors are anticipating with pleasure the possibility of this Faculty holding one of its semi-annual meetings on the Sanitarium premises, when a symposium on tuberculosis might be the order of the day, and you will all have the opportunity of seeing for yourselves the beautiful spot Maryland has chosen for her consumptives.

The Plan Committee, in the meantime, has not been idle. Drawings of every existing institution in this country, and some of those from abroad, were obtained and carefully studied by ourselves and our architects, Messrs. Wyatt & Nolting, with a view of combining all the good features of each, and excluding those found by practical experience to have proven defective. The Committee further sent a circular letter to all the expert sanitarians in the country requesting them to give their views in writing as to just how an ideal sanitarium should be constructed. Replies were received from Dr. Herbert King, of Liberty, Dr. Lawrason Brown, of

Saranac, Dr. David Lyman, of Gaylord Farm, Dr. Charles Elliott, of Muskoka and Dr. H. L. Barnes, of the Rhode Island State Sanitarium, Wallum Lake. It is needless to say that all these letters contained much valuable information, and if published in combined form should furnish enough data for any other state committee engaged in a similar undertaking.

The result of all these deliberations was that the Committee decided that an administration building, dining hall and infirmary should be built in one building, and that the patients' quarters should all be built on the lean-to system as devised by Dr. King and improved by Wyatt & Nolting, such lean-tos to be grouped around the central building. The plans for the power heating and lighting plant and laundry have not as yet been completed, but they will all be of the most approved and modern design. In short, I think I may safely say that by the first of the New Year, Maryland will have added another institution to her list which will compare favorably with some of her already existing public institutions which have a world-wide reputation, and of which she should be justly proud. And now, just a word as to the scope of this sanitarium as tentatively outlined by the Board of Directors.

It will be open to all white residents of the State of Maryland who are suffering from tuberculosis in any of its forms, medical or surgical. Each individual will be charged a uniform rate, the exact amount not as yet having been determined. This charge will be necessary until the State sees fit to increase the annual appropriation for maintenance. The present plans call for about sixty patients, and as the average cost per patient per week will probably be in the neighborhood of $10.00, it will cost us roughly about $30,000 a year to maintain the hospital at full capacity. As our present maintenance fund is only $15,000, it will be necessary to charge each patient about $5.00 a week, or else take only thirty cases. I trust the next Legislature will increase the fund so that we will be able to take care of patients free of charge, or else pass laws making it incumbent upon the County to pay for their indigent consumptives, as they do now for their insane. The Committee on Scope and Plan have also decided that the sanitarium shall only be open for cases in the early stages of the disease that admit of a possibility of a permanent cure. My experience at Eudowood Hospital has been that physicians are wont to put off sending their patients to the hospital until the disease has so far advanced as to make any permanent benefit an impossibility. It will not be good economy on the part of the State to admit to the hospital advanced or hopelessly ill persons, who at best can only be temporarily patched up, and who will surely relapse after discharge, and by the prolongation of their sufferings become an increased burden on their friends or the community. The method of admission to the hospital has not yet been definitely determined,

but the medical members of the board will probably act as examining physicians in their several localities, and I do hope that I shall not be overwhelmed in Baltimore City with a lot of far advanced cases seeking admission.

In this connection, before closing, I should like to say just one word about the use of tuberculin as a diagnostic agent in very early and obscure cases. We have been using this agent quite extensively at Eudowood with uniformly good results and without any untoward or deleterious effects whatever. In proper doses, I think it is perfectly safe, and it has been of immense value to us in clearing up doubtful cases in whom a positive diagnosis could not have otherwise been made. It has been my practice of late to give tuberculin to all persons who have been recently associated with cases of tuberculosis, and it has been remarkable the number of positive reactions that have been obtained. Such persons never fail to do well under sanitarium treatment, and I think I should say that in about three months' time can be regarded as permanent cures. We are at Eudowood, and will be at the State hospital, only too glad to take suspects for such injections, for I would rather see a dozen negative reactions than get one case when it is too late to do anything. Let me therefore beg of you gentlemen to see to it that when the institution is opened, it will be used to fulfill the purposes for which it was built.

Book Reviews.

MANUAL OF THE DISEASES OF THE EYE. For Students and General Practitioners. By Charles H. May, M.D., Chief of Clinic and Instructor in Ophthalmology, College of Physicians and Surgeons, Medical Department of Columbia University, New York, 1890-1903; Ophthalmic Surgeon to the City Hospitals, New York; Adjunct Ophthalmic Surgeon to Mt. Sinai Hospital, New York, etc. Fifth edition, with 362 original illustrations, including 22 plates, with 62 colored pictures. Price $2. New York: William Wood & Co.

We have before congratulated Dr. May upon his wonderful success with this little publication and exhausted our supply of good expressions in praise of the former editions. This, the most recent edition, shows still more improvements, and will undoubtedly hold the continued support of the profession, teachers and students alike. We consider it by long odds the best and most satisfactory manual of ophthalmology for the undergraduate student that has yet appeared, and wish its author all the success his excellent work deserves. H. O. R.

PROCEEDINGS

OF THE

MEDICAL AND CHIRURGICAL FACULTY

OF MARYLAND

Editorial and Publishing Committee.

ALEXIUS MCGLANNAN, M.D. J. A. CHATARD, M.D. JOHN RUHRAH, M.D.

Secretaries of the County Societies are earnestly requested to send reports of meetings and all items of personal mention and of local or general interest for publication addressed to Dr. Alexius McGlannan, 847 North Eutaw Street, Baltimore.

$50,000

TO BE RAISED BY APRIL 30, 1908

"Watch It Grow"

	1st Wk.	2d Wk.	3d Wk.	4th Wk.	Totals.
April					
March					
February					
January					
December					
November	$451	$1,001			
October	$480	$195	$280	$245	$1,200.00

Subscriptions to October, 1907	$4,273.00
Aaron Friedenwald Fund	$1,246.87
Osler Fund	$19,140.00
Value of Present Realty	$15,000.00

"WATCH IT GROW."

The New Building Fund during October and the first two weeks in November has shown a most gratifying increase since last month's report (see illustration), but there is still room for great improvement and increase in the subscriptions which we hope will soon be forthcoming.

It is expected that all the counties will enter into this campaign for the New Building with enthusiasm, especially as with our enlarged facilities in the New Building, the shipment of books and specimens, when wanted, can be done most promptly. A member of each county society has been appointed to take charge of this work, so that each county will be able to give a large subscription, as a body; even though some members may have already given individual subscriptions.

There are still a number of doctors who have not yet subscribed and this delay makes it all the harder for the members of the different committees to collect outside funds; please look into this important matter and see that your name does not block some outside subscription by being absent from the list of medical contributors, this being always the first question brought up by the laity.

The meeting on November 15th. which was devoted exclusively to the New Building Campaign was financially a great success, as about $6,000. was raised by pledges of those present; this was quite remarkable as less than one hundred members attended out of the large city membership of the Faculty. All praise must be given to those enthusiasts, but where were the other city members?

The invited guests certainly made stirring appeals in their speeches, which those present much appreciated and responded to loyally. But what of those who did not attend, surely you, the absent ones, want a New Building. Which class do you wish to be placed under in Dr. Stephenson's classification: "Weak-sighted, near-sighted or far-sighted." Those present and those who have already contributed or worked on committees are certainly far-sighted, the absent ones—"The weak-sighted member sees nothing in medical organization. He cannot be induced to attend meetings and so remains as a worthless asset to the society. The second class, Dr. Stephenson describes as near-sighted. These members can only see the benefits and results of organization which come very close to them and which affect them personally. This class should be encouraged, as there is hope for them, and some day they may be able to render good service. The third class are the far-sighted men who are always on the lookout for something good in medical organization and who are trying to better conditions, bring in the new members, aid the secretary and encourage the society in all good work. They are the members who attend the society meetings, rain or shine. They readily perceive the benefits of medical organization to themselves and to their patients.

They are fully alive and are the members who are moving forward and upward."

The "Medical Night" at Ford's on December 3rd must be made a great success, so be sure to attend and give your hearty support to the undertaking.

SEE THE THERMOMETER—"HELP IT RISE."

PAID SUBSCRIPTIONS TO THE NEW BUILDING FUND TO NOVEMBER 10, 1907.

Dr. L. McL. Tiffany	$1000.00
Dr. Chas. O'Donovan	200.00
Dr. W. A. Fischer	200.00
Mr. W. A. Putnam	100.00
Dr. S. Greenbaum	100.00
Dr. L. F. Barker	50.00
Dr. C. B. Gamble	50.00
Through Dr. M. Lazenby	50.00
Dr. J. Ruhrah	50.00
Dr. J. S. Huck	25.00
Dr. Charles Getz	25.00
Dr. W. B. Wolf	25.00
Dr. H. W. Gaddess	25.00
Dr. E. Kerr	25.00
Dr. J. A. Chatard	25.00
Dr. A. P. Herring	25.00
Dr. E. Plummer	25.00
Dr. L. M. Allen	20.00
Dr. C. M. Cook	20.00
Dr. A. F. Ries	15.00
Dr. W. R. Dunton	15.00
Dr. W. E. Wiegand	15.00
Dr. J. S. Davis	15.00
Dr. O. E. Janney	15.00
Dr. C. A. Penrose	10.00
Dr. H. M. Simmons	10.00
Dr. J. K. B. E. Seegar	10.00
Dr. D. MacCalman	10.00
Dr. C. Keller	10.00
Dr. S. Rosenheim	10.00
Dr. J. G. Stiefel	10.00
Dr. S. M. Cone	10.00
Dr. T. J. Talbott	10.00

Dr. H. C. Algire	10.00
Dr. E. M. Wise	10.00
Dr. H. C. Davis	10.00
Dr. C. A. Clapp	5.00
Dr. G. A. Fleming	5.00
Dr. J. Bordley, Jr	5.00
Dr. S. G. Davis	5.00
Dr. E. Hayward	5.00
Dr. H. E. Knipp	5.00
Dr. R. P. Carman	5.00
Dr. G. A. Thiede	5.00
Dr. E. Novak	5.00
Dr. F. E. Brown	5.00
Dr. E. B. Claybrook	5.00
Dr. L. Goldbach	5.00
Dr. A. Keidel	5.00
Dr. A. D. Hirschfelder	5.00
Dr. H. D. Lewis	5.00
Dr. A. L. Tumbleson	3.00
Dr. J. S. Garrison	1.00
Dr. J. S. Fischer	1.00
Dr. E. Douglas	1.00
Cash	1.00

PAID SUBSCRIPTIONS TO THE OSLER TESTIMONIAL FUND.

Sherwood, Dr. Mary, The Arundel	$50.00
Stokes, Dr. J. Ernest, Salisbury, N. C	25.00
Talbott, Dr. Thos. J., 2505 Pennsylvania Ave., Balt	10.00
Thayer, Dr. Wm. S., 406 Cathedral St., Balt	100.00
Thomas, Dr. F. S., Charleston, W. Va	50.00
Thomas, Dr. Henry M., 1228 Madison Ave., Balt	100.00
Watson, Dr. Wm. T., 2128 St. Paul St., Balt	50.00
Welch, Dr. William H., 807 St. Paul St., Balt	500.00
Welsh, Dr. Lillian, The Arundel	50.00
Williams, Ed. P., Esq., 100 Canal St., Cleveland	500.00
Williams, Dr. J. Whitridge, 1128 Cathedral St., Balt	500.00
Wolf, Dr. W. B., 13 W. Franklin St., Balt	10.00
Woods, Dr. Hiram, 842 Park Ave., Balt	50.00
Young, Dr. Hugh H., 330 N. Charles St., Balt	500.00
Johns Hopkins Hospital Alumni through Dr. T. R. Brown	1000.00

(List of names for above will be published later.)

FEE TABLE.

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

Revised, May 1907.

The following revision of the fee table, as ordered by the Council of the Faculty, is printed that every member throughout the State may note the changes introduced:

MEDICAL AND SURGICAL ATTENTION.

First visit in any case of sickness	$2 to	$20
Each subsequent visit	2 to	5
First consultation visit	5 to	100
Each subsequent consultation visit	5 to	100
Single visit and advice in special cases, where the physician is not the regular attendant	5 to	25
Distant visits, for every mile over two miles in addition to the usual charge, night visits double	1 to	5
Night visits, between 10 P. M. and 7 A. M.	5 to	10
Detention with patient all night	10 to	100
In case of several patients in one family, charge the visit to one, and to the others each one-half the amount charged to the first.		
Advice at physician's office, night double	2 to	10
Advice anywhere except at office	2 to	10
Advice by telephone	2 to	10

SURGICAL OPERATIONS.

*Minor	5 to	100
Major	100 to	10,000
Obstetrical attention	20 to	1,000

MISCELLANEOUS.

Microscopical or chemical examination of blood, sputum, urine or other secretions	5 to	50
Administering anæsthetic	5 to	100
Gonorrhœa or syphilis, in advance	15 to	500
Written opinion as to health of patient	10 to	50
Oral opinion as to health of patient	5 to	25
Expert testimony or detention at court per day	50 and up.	
Opinion involving a question of law	50 to	150
Examination for life insurance	5 to	10
Family physician's certificate for life insurance	5 to	10
Certificate of cause of death for life insurance		10
Post-mortem examination for legal investigation	100 to	500
Post-mortem examination for the family	25 to	50

*By the term minor surgery is meant those small operations or dressings which usually do not endanger life, require neither an assistant nor general anæsthetic.

All services not herein specified to be rated in accordance with the above scale of charges.

I. The foregoing table contains the STANDARD FEES of the medical profession of Maryland. All bills should be rendered in conformity with the above fee table. They may be *increased* according to the judgment of the practitioner concerned; in all cases of extraordinary detention or attendance; also in proportion to the importance of the case, the responsibility attached to it, and the services rendered, when these are extraordinary. They may be *diminished* at the discretion of the physician, when he believes the patient cannot afford to pay the regular fees, and yet is able to make some compensation. It shall, however, be considered *unprofessional* to diminish the standard fees with a view to mercenary competition.

II. It is not designed by these regulations to prevent gratuitous service to those who are incapable of making remuneration without distressing themselves or families.

III. It is expressly enjoined on the members of the profession to decline all offers of a specific fee for attendance during any given period of time, as a measure unequal and often unjust in its action on one or the other of the parties, and as derogatory to the character and dignity of the medical profession.

IV. Every physician should present his account immediately after ceasing attendance in any given attack of sickness, especially in all cases of surgery or midwifery.

V. It is desirable that consultation fees should be collected at each visit.

COUNTY SOCIETY MEETINGS.

FREDERICK COUNTY.

A REGULAR meeting of the Medical Society of Frederick County was held on Wednesday Nov. 13th inst. This being the annual meeting the following officers were elected for the ensuing year, viz:—President, Dr. D. E. Stone, Sr., of Mt. Pleasant; Vice-Presidents, Drs. E. D. Neighbors of Lewistown, and T. C. Routson of Buckeystown; Sec'y, Dr. Ira J. McCurdy of Frederick; Treas., Dr. W. A. Long of Frederick; one member of Board of Censors to serve for three years, Dr. C. T. Sappington of Frederick.

Resolutions upon the following deceased members, were presented and ordered spread upon the minutes: Dr. E. Oliver Belt, Dr. Robert L. Annan and Dr. E. E. Mullinix, who died during the past year.

Dr. C. R. Dufour of Washington, D. C., read a paper, "The new technique in surgical treatment of throat diseases."

"Scarlet fever" was discussed by Drs. C. F. Goodell, D. F. Stone, F. B. Smith, and I. J. McCurdy.

Next meeting Jan'y 8th '08.

QUEEN ANNE COUNTY MEDICAL SOCIETY.

A MEETING of Queen Anne County Medical Society was held Wednesday, November 13, at Centreville, with six members present, the guest of honor being Dr. W. R. Dunton, Jr., of Baltimore.

The following program was carried out:

1. Business meeting.
2. The borderland of insanity. Dr. W. R. Dunton, Jr., Balt.
3. Election of officers:

    President—Dr. Howard R. Hopkins.
    Vice-President—Dr. W. H. Fenby, (re-elected).
    Secretary—Dr. E. F. Smith, (re-elected).

The above meeting was a very interesting and satisfactory one, in spite of the small attendance.

THE MEDICAL SOCIETY OF WASHINGTON COUNTY

MET in regular session Thursday, Nov. 14, 1907, at 1 P. M., in the Washington County Library Building. Program:

1. Routine business, including:

    Election of officers,
    Election of consulting Hospital staff,
    Collection of annual dues.

2. Annual address by the retiring President, Dr. E. M. Schindel.

3. Paper, Diphtheria:—Cause, prevention and treatment, with special reference to antitoxin.

Discussion opened by Drs. D. C. R. Miller and J. W. Humrichouse.

PAPERS READ AT THE ANNUAL MEETING APRIL 23-25, 1907.

THE PRESENT STATUS OF THE ANTI-TUBERCULOSIS MOVEMENT IN MARYLAND.

John S. Fulton, M.D.

In order to appreciate the present status of the anti-tuberculosis movement in Maryland one must recall briefly its status a few years ago, say in 1901. Papers read before this Faculty by Dr. Osler, Dr. Gichner, Dr. Jacobs, the late Dr. Edward Schaeffer, and others, had planted a little leaven among us of the medical profession, but no medical man, so far as I know, had made a popular address on that subject. The Eudowood Hospital for Consumptives, the only refuge in the State for this class of sufferers, was working hard to maintain its beneficent existence, and the profession was supplying it with an excessive number of hopeless cases. The Laennec Society was in the second or third year of its existence, and Miss Dutcher was making her memorable studies of tuberculosis in the homes of the poor. In December, 1901, the President of the State Board of Health, in his letter transmitting the report of the Board, called the Governor's attention to the urgency of the tuberculosis problem, and the Board authorized me to follow up this letter of Dr. Welch by an interview with Gov. John Walter Smith. The Governor met this overture by the State Board of Health more than half way, and in his message to the Legislature, in January, 1902, he gave earnest consideration to the tuberculosis problem. The Assembly passed a bill offered by the State Board of Health and providing for the creation of a Tuberculosis Commission. Governor Smith, whose duty it was to appoint the Commission, consulted the Board, and made his appointments in precise accordance with the recommendations of the Board. He might have made as good a Commission without the advice of the Board, but it is noteworthy and significant that then and afterwards Governor Smith trusted his official medical advisers. From then till now, and whether in or out of public office, Ex-Governor Smith has been a consistent and active supporter of the anti-tuberculosis movement. The Tuberculosis Commission, which organized in June, 1902, was the chief agency in bringing the anti-tuberculosis movement up to its present status, and the two years of its existence will be for a century the memorable years in the history of tuberculosis in Maryland. There are four points of special interest in the present status of the Maryland anti-tuberculosis movement.

1. *Existing institutions have been greatly strengthened.* The Eudowood foundation, which had good though remote hopes of expansion five years ago, has strengthened its claims to popular support very much in the past two or three years. Its capacity

is much enlarged, its selection of cases is better, it has a trained resident physician, it employs a nurse constantly in the after-care of patients, and its trustees can look upon its future with confidence.

The work which Miss Dutcher began under the initiative of the Laennec Society is now continued by the Instructive Visiting Nurses' Association, which has three nurses whose time is wholly devoted to visiting the tuberculous in their homes. Another tuberculosis nurse is constantly employed by the Phipps Dispensary, and in a short time the number of tuberculosis nurses in Baltimore city and its environs will probably be increased to eight. Easton has a tuberculosis nurse, and when the usefulness of the visiting nurse for tuberculosis is generally appreciated they will be found also in Cambridge, Salisbury, Annapolis, Frederick, Laurel, Westminster, Cumberland, Brunswick, Hagerstown, and wherever else there are as many as 3000 people in one community.

2. *New agencies have been brought into existence in the past three or four years.* A new Tuberculosis Commission was appointed in 1904 to make plans for a special hospital. This Commission is now succeeded by a Board of Managers having $100,000 in hand to provide a State hospital for consumptives. The site has been selected, the drawings are made and Dr. Buckler will describe this new work this afternoon.

Mr. Henry Phipps has presented the Johns Hopkins Hospital with a tuberculosis dispensary. The University of Maryland has a special dispensary, the Homeopathic Hospital has a special dispensary, and the new St. Luke's Hospital will have special arrangements for the care of the tuberculous. Other dispensaries are realizing the need of a department for tuberculosis separate from the departments of throat and chest diseases. The trustees of Bay View have had for three years a hospital for advanced cases. It is totally inadequate to the demands upon it, and they are now planning extensive improvements and distinct medical supervision of their tuberculosis cases.

Finally Mr. Jacob Epstein has given a sum of money to do whatever seems best for the prevention and relief of tuberculosis among the Jews. It is a gift of rare wisdom, for it is given to the Federated Jewish Charities without specifying the manner of its expenditure, and a first-rate committee of clever and energetic young men will decide what particular form this new agency shall take. This gift of $25,000 is reinforced by pledges from other sources assuring an annual income of something like $10,000.

3. *In the recent progress of the anti-tuberculosis movement the medical profession has discovered its true relations to the lay public, and especially to the lay workers for social betterment.* The chief evidence of this is the existence of the Maryland Association for the Prevention and Relief of Tuberculosis. The medical profession is responsible for the organization of this association in December, 1905. It has a paid secretary, devoting all his time to the campaign against tuberculosis. This executive secretary is

not a medical man, but a trained sociologist, and a majority of the other officers of the Association are also laymen. Before one ventures to express his satisfaction with the state of popular enlightenment which the situation signifies, one should acknowledge, as I do gladly, the path of professional progress which this situation opens up to medical men. This Association has now in hand about $11,000 raised by popular subscription for the prosecution of this work in the coming year. This money will be spent under the advice of medical men for the prevention and relief of tuberculosis. Its operations are not confined to the city of Baltimore, where its offices are. There are several branch associations in the counties, and I can think of no better way for county societies to exercise themselves in public endeavor than by aiding the State Association for the Prevention and Relief of Tuberculosis to organize and maintain local branches. This Association has made medical evangelists out of a large number of doctors. Public lectures in all parts of the State to large audiences and to small ones have been given by medical men who five or six years ago would have doubted the propriety of speaking to a lay audience about tuberculosis. Literally hundreds of such lectures have been given in the past two years, and I know nothing that makes me as proud of my profession as to see a really busy doctor devote an evening to plain talk to a score or so of plain people about tuberculosis. This work has been tremendously profitable to the public. It has been more profitable to the profession, for it has released us from our traditional reserve, and put into action an energy, which will eventually be brought to bear on other problems besides tuberculosis.

4. *The State has excellent laws for the restriction of tuberculosis.* There are two of these laws. One of them provides for the registration of tuberculosis, and the other for its domestic prophylaxis. I suppose there were probably some hundreds of physicians in Maryland four years ago who had misgivings about the practical effectiveness of a registration law. The Maryland law will have been in operation two years on the first of May. More than 3000 registrations were made in the first year, and when all duplicates were counted out the number of cases registered was found to be just short of 2500. Nothing like this has occurred anywhere else in the experience of any Board of Health, and the significant thing about it is that no coercive measures were used in operating the law. Indeed the law has operated itself, for the State Board of Health cannot spare a man for 20 minutes a day to look after this registration. I intended to make note of the first 100 physicians who registered their cases, and to make to them some special acknowledgment, but since the registration must, under the provisions of the law, be kept strictly confidential, I had to give this up. But I did make, for my own satisfaction, a list of the first 300.

The first 300 physicians to fall into line in this business are all young men. Not one of them is over 85 years of age. They all belong to the twentieth century, and to the era when the medical

profession is actually doing what it has been, for 50 years, professing to be able to do. The number of such men is much larger than 300 at this time, and is steadily growing, and growing, as I have said, without official stimulation. The registered cases I am forbidden to describe in detail, but I can say that the social distinctions found in this mass of personal information correspond closely to the distinctions in the population of Maryland. The registration does not discriminate. It is not unusual for consumptives to register their own cases. It is not rare for physicians to be asked by relatives to register cases. This morning there were eight registrations before 12 o'clock. Among these was the child of a physician registered by his father. This was not a remarkable occurrence, though it is remarkable that of a limited number of such instances one should have occurred this morning.

The second law on tuberculosis provides for the domestic prophylaxis, the physician being employed and paid to perform certain simple services. Most of you are familiar with this work, and I need not describe it. Suffice it to say that the State now provides sputum cups, and other prophylactic supplies for all registered cases, and that these supplies have been distributed to thousands of consumptives. Two counties wholly neglect this prophylaxis, St. Mary's and Garrett counties. Other counties do it badly. In some counties this work is thoroughly well done. The law also requires all houses to be disinfected after the death or removal of consumptives. In Baltimore city, this work is thoroughly done by the Health Department. In many of the counties these disinfections are well done, but in two counties, St. Mary's and Garrett, it is wholly neglected. Wherever the medical profession want this work done, it is done.

The condition of this tuberculosis work in each community is, for me, an index of health of the professional conscience in that locality. On that index I should judge Calvert county to be about the most wholesome part of Maryland in a professional way, with Dorchester county a good second, both of them being better than Baltimore city.

One remarkable phase of the situation in Maryland is that the tuberculosis fight is coextensive with the State. Better organized campaigns are going forward in some large cities, but there is no State lined up against tuberculosis as Maryland is.

One more reflection, and I am done. The medical profession has spent money and labor on this work. The funds which supported the initial movement to arouse public sentiment here in 1904 came largely from the pockets of physicians. I doubt if they knew what they were doing either with their money or with the time and labor which they invested in this subject in 1903 and 1904. Their imaginations could not possibly have foreseen the results. Compare the insignificant accounts of money then available, and the few hundred dollars raised by private subscription for the initial campaign in 1904, with the quarter of a million dollars now invested or available, and compare if you can the state of the popular mind

and of the professional mind in 1903 with the present state of enlightenment, and of fruitful activity both in and out of the profession, and I think you will agree that the rewards far exceed the reasonable hopes of four years ago. The present status of the anti-tuberculosis movement in Maryland is, I think, in the highest degree creditable to the medical profession, and every man of the many who helped to bring the campaign up to its present status deserves the approval of his State, of his profession, and of his own heart.

MEDICAL INSPECTION OF THE PUBLIC SCHOOLS IN BALTIMORE.

By J. Hall Pleasants, M.D.

Medical inspection of the public schools has now been on trial in Baltimore for over two years. Few familiar with the work will deny that success has been more rapid and more complete than even its most sanguine advocates hoped. That it would ultimately become firmly established few of those who looked into the work elsewhere for a moment doubted, but that it would in such a short time demonstrate its value and win the approval of the public has been more than gratifying.

I am especially glad to be able to present to the profession a brief outline of what has been done up to the present time, and to explain as fully as possible what the Department of Health aims to accomplish. The success of inspection depends not upon the work of the examiner alone. Nothing can be accomplished without the hearty co-operation of the profession at large. For this we now appeal. Except in the matter of vaccination and of contagious diseases the Department has practically no *authority* which can be *enforced* as regards the health of the children. Upon the family physician must rest the proper treatment of the child. He it is who has the health of the child in his hands, and upon him devolves the carrying out of the examiner's recommendation. It is but fair to say that the vast majority of the profession in this city has shown a praiseworthy disposition to second the efforts of the Department and to make them effectual. I regret to say that in a few instances a less broadminded spirit of reciprocity has been shown, due possibly to a mistaken idea of the purpose of the inspection.

In the autumn of 1904, through the efforts of Mrs. William M. Ellicott and several other ladies, the interest of the Federation of Women's Clubs of this city was directed to the subject of school inspection. The Health Department and the School Board were already alive to the importance of the subject and to its success elsewhere, and welcomed this interest on the part of the clubs as a powerful aid in establishing a public sentiment in the matter. When the moment seemed opportune Dr. Bosley, representing the Health Department; Mr. Van Sickle of the School Board, Mrs.

Ellicott of the Federation of Women's Clubs, and myself as somewhat familiar with the work of inspection elsewhere, appeared before the Board of Estimates and gave a brief outline of the proposed work, and asked for a small appropriation to start. This was granted, and in a short time with an appropriation of $2000 two inspectors and one nurse were put in the field under the charge of the Health Department. Fortunately for the success of the work the fatal error was not made of attempting to cover at first the entire field. A few groups of schools were selected and these were covered as carefully as possible. The school season of 1905-1906 saw an increase of the number of inspectors from two to five, with three nurses instead of one. The experience of last year demonstrated that the nursing force was insufficient, and this winter five nurses were appointed, and one assigned to each examiner.

Medical inspection of the school children aims primarily to improve the hygienic conditions surrounding the child, to correct existing defects in the individual and to prevent the spread of contagious diseases. *The hygienic condition of the city schools* is one that calls for most serious consideration. The buildings that have been erected in the past few years are models as regards ventilation and light, but many of the buildings of 30 or 40 years ago, as well as the temporary quarters in which the overflow is housed, are a disgrace to a civilized community. Forty or more children huddled together in a small room with a ceiling not over 10 feet in height, a huge red-hot stove in one corner, ventilation possible only from open windows immediately over the desks, or, worse still, no open window at all, is a picture too often seen. Is it remarkable that the tonsils, standing guard over one of the principal portals of entry of infection, show a percentage of enlargement more than twice as great in such surroundings as is seen in better ventilated buildings? In a horribly ventilated school annex of this kind situated over a paint shop, the number of hypertrophied tonsils was 24 per cent., while among children of exactly the same class housed in a new school building less than a block away the number was 11 per cent. This is no criticism of the School Board, for it does the best it can with the means at its disposal. It is, however, a campaign argument in favor of the school loan to be voted on this spring.*

As regards *lighting conditions,* many of the old buildings are in a deplorable state. A widespread negative reply to the question, "Can you see the blackboard well?" on further investigation proves that we are not so often dealing with defective vision as with bad light. In the new schools not only the amount of light, but its direction and the color of the wall covering, all enter in planning the school room.

In the new schools we also have *the size and height of the desks* regulated according to the size of the child. The number of

*This loan has since been approved at the spring election.

stooping shoulders, scoliotic backs and bad eyes to be attributed to the old method of making a five-year-old child and a long-legged boy of 16 fit the same desk, could a count be made, would make us shudder. These are some of the things to which medical inspection has helped to draw attention, and in which it has assisted the School Board in bringing about a universal demand for better things.

The Police Census of 1906 showed 99,479 children between the ages of 5 and 15 in the city. Many of these attend private schools, or for various reasons do not go to school at all. There are about 78,500 children enrolled in the elementary public schools. The average daily attendance is about 52,000. There are about 66,000 children in more or less regular attendance in the elementary schools, or "in care," as expressed by the school authorities. With five examiners and five nurses this means that each physician and nurse is responsible for about 13,000 pupils during the season.

The actual work of *examination* is carried on in the following manner: Each inspector is assigned four or five groups containing some 18 to 20 schools. Presenting himself at a group center as soon as the school work is under way about October 1st, the regular inspection begins. Each child is given a filing card with name, date, age, room and grade filled out by the teacher. This card contains a long list of the more common diseases of the eye, ear, throat, nose, skin, hair, etc., as well as spaces to record the nutrition, condition of the teeth, character of the vaccination mark, etc., to be underscored or erased as each case requires. These cards are filed in a cabinet in each school. If a condition amenable to treatment is discovered, a small *"notification card"* is given to the child in a sealed envelope addressed to the parent. This card contains the name of the child and the disease, and advises the parents to consult the family physician for treatment, and to have the physician sign an attached "return card" showing that the child is under treatment. In the case of pediculosis capitis a special card with direction for ridding the hair of vermin is given. This is the only case where treatment is advised, except in cases where the parents ask the school physician for advice, or where the nurse in the home offers suggestions as regards hygiene and diet, or assists in helping the mother to carry out the orders of the family physician.

If the child is found suffering from a contagious disease, or when too filthy to remain in the school, or for any other reason is a menace to the health of others, an *"exclusion card"* is given and the child sent home.

The nurse assists in the examination of the children, who are brought by her into the examining room in groups of eight or ten. Her business is to prepare the children for examination, to expose the vaccination marks, and to expedite the work in various ways. As will be shown later, this, however, is the least important part of her work. The gait, nutrition, appearance of the skin are noted, the throat and teeth examined, the question of hearing, eye-sight

and headaches enquired into, and the hair carefully inspected. If there is reason to suspect disease of the heart or lungs these are examined. In this more or less complete recorded examination from about a hundred to a hundred and fifty children are examined daily, according to the rapidity of the examiner, and the condition of the children. The inspector passes from school to school, and should be able to finish the first inspection of his schools in about five months. As soon as this is completed a re-examination of his groups is again undertaken. In this second, or in subsequent examinations, a complete recorded examination of all the previous absentees is made. In addition to the examination of the absentees, all children in whom defects were previously found are re-examined to determine whether treatment has been employed, and if so, what has been the result. This is noted upon the "recorded examination card" previously filled out at the first inspection. In this way accurate figures as to the value of the work accomplished can be obtained. In both the inspection and reinspection the teacher of each class is consulted and requested to report any defects, either physical or mental, observed by them. Daily and monthly reports are sent by the inspectors to the Health Department.

The figures for the present season's work, although necessarily incomplete, are of interest. Up to March 1st 50,620 children had been examined. About 10,000 additional children, principally absentees, will have recorded examinations made before the close of the season. This will place the total number at about 60,000 for the year. Of the 50,620 inspected up to March 1st 20,795 defects were found—a percentage of about 41. These were distributed as follows:

Oct. 1st, 1906, to March 1st, 1907.

Number examined	50,620
Number showing defects	20,795
Ear	283
Mouth	1,232
Infantile paralysis	24
Glands	386
Tubercular gland, bones, joints	38
Infectious diseases	15
Other diseases and deformities	102
Eye	3,481
Nose	2,186
Skin	458
Debility	538
Hair (ringworm and pediculosis)	5,488
Nervous system	141
Throat	5,219
Unvaccinated	1,203

The value of the work cannot be finally determined until the re-examination is finished, and the figures tabulated. A school of the average grade in Southwest Baltimore selected at random showed the following result in a recent re-examination: In this school out of a total attendance of about 475 pupils, 157 children, who had previously been found defective and advised to consult their family physician for treatment, were re-examined with the following results: Of 42 cases of pediculosis previously reported 27 were entirely free from vermin. In 35 cases of eye strain correction had been made in 12. Of 31 cases of adenoids 10 had been removed and 6 were being treated. Of 65 cases of enlarged tonsils 9 had been removed, 16 otherwise treated and improved. A school more favorably situated would show a larger percentage treated, while the figures among the schools attended by foreigners or negroes would fall below these.

The great value of the *school nurse* lies in the fact that it is largely due to her influence in the homes that the more ignorant and indifferent parents are induced to have their children attended to. One discouraging feature of the matter is the frequency with which unscrupulous physicians for a small fee sign the cards stating that the child is under treatment without even seeing it. Two years' experience with the work has made me very familiar with the difficulties encountered, and keenly alive to the direction in which the health and well-being of the school children can be improved by the extension of medical inspection.

From the standpoint of the community at large we have a *better vaccinated city* than in the past. We no longer have to depend upon an often worthless certificate of vaccination, but the arm of every child in the schools is actually examined, and if a satisfactory mark is not found vaccination is performed by the Health Wardens.

The *cleanliness* of the children has been improved not only as regards such filth diseases as pediculosis capitis, pediculosis corporis, scabies and impetigo, for which they are excluded if the case is aggravated, but grime, foul odors and filthy clothes are sufficient causes for exclusion.

In schools where epidemics of contagious diseases are prevailing, early cases of mumps, chickenpox, measles, etc., have been detected and excluded.

In regard to the value of school inspection as a direct aid in dealing with the *tuberculosis* problem, the results have been rather different from what was expected. Of course it is out of the question for one physician to examine the chests of the 13,000 children under his charge. In every case, however, where the appearance of the child was suggestive, or the suspicions of the teacher were aroused, a careful examination was made. In scarcely any case was pulmonary tuberculosis found, although bone and gland tuberculosis was not uncommon. I am inclined to believe that there is very little active pulmonary tuberculosis in the schools, not only because the school age is one of minimum susceptibility to its active development, but because when present there is not

the same incentive to a parent to keep a child suffering from the disease at school as there would be to keep a wage-earner at work. That implantations very frequently occur during the school age is very probable, however, so that the improvement of school hygiene will indirectly be a great factor in stamping out the disease. Medical inspection of the teachers, recently inaugurated by the School Board, will also be an important aid, as infection from teacher to pupil has been shown to be a factor in the spread of the disease.

The present system of education of the *mentally defective and of the incorrigibles* in the public schools is entirely wrong. There should be special schools for these classes. It is neither fair to the normal pupils nor to the deficients to mix them in the same classes as is now done. There is no longer a question that often a very close relationship exists between many so-called mental defects and physical disease. Only recently I discovered that a so-called incorrigible was really a cretin. A child suffering from impaired visio,n or from deafness due to otitis media, or adenoids, often passes as mentally deficient, until the true cause is found and corrected. Sensitive children, if their true condition is not recognized, fall back in their studies, become discouraged and defiant, and finally enter on a career of truancy. The close relation between truancy and physical defects is now generally recognized. The presence of *epileptics* in the schools is also a serious problem. To deprive such children of an education is most unfair, yet imagine the effect upon others of a child having frequent convulsions in the class room, as often occurs. Such cases should certainly be separated.

Malnutrition among the children has received careful attention. The frequency with which undersized and under-developed children are met with in certain sections of the city is a serious problem. The value of the school nurse in visiting the parents of such children and urging better feeding and hygiene cannot be overestimated, for it is not always a question of mere poverty, as in many cases we are dealing rather with dense ignorance in elementary matters of diet. Without increasing the cost of food, the nurse often has been able to bring about a change in its character for the better, so that when seen a few months later the child is scarcely recognizable. In other cases where poverty was at the root of the trouble the attention of the proper charitable agencies has been invoked with good results.

The general question of *cleanliness* is turned over largely to the nurse with marked success. In aggravated cases, at her suggestion, filthy children are excluded, if mere persuasion moves neither the child nor the parent. Nor is it to be assumed that the negroes are the worst offenders in this respect. I will admit that overindulgence in bathing is not one of their vices, but I think that they bathe as much or more than the foreigners, among whom the fashion of sewing up the children's clothes for the winter prevails. In the matter of pediculosis capitis the negro schools are far better off than the white schools. In an average negro school of the

poorer class I have rarely found more than 8 per cent. of cases among the girls, while in many white schools the percentage runs above 30 per cent. That this is entirely a matter of cleanliness, however, I do not claim, for the nits seem to cling with much greater difficulty to kinked hair.

I have already incidentally referred to the important part played by the *school nurse*. I go so far as to say that the success of the work lies more with her than with the physician. If it were necessary to abandon either I should say retain the nurses. It is she who gets in the good work in the homes of children, and it is she who is able to bring about permanent improvement in matters of personal and home hygiene, diet and cleanliness in a way that all the *generalizations* of the physician fail to accomplish. Dr. Bosley is very wise in his decision that the next increase in the scope of the work should be in the direction of additional nurses.

The *power of exclusion* is the great weapon in the hands of the inspector, but it is a weapon to be used with much care. Contagious diseases such as measles, scarlet fever, mumps, chickenpox and acute tonsilitis are, of course, invariably excluded, to be readmitted after a certain period. Scabies and impetigo are always excluded. Ringworm of the scalp or face, if active, is excluded. Pediculosis capitis is invariably excluded if living parasites are found. If only nits are present, however, exclusion is not resorted to unless, after warning, the parents fail to begin treatment. It would at first seem that exclusion would cut down school attendance, or afford an opportunity to the child for a much desired holiday. This is not true, however. An excluded child is visited frequently by the nurse, who endeavors to get the child in condition to return. The compulsory attendance law is also a powerful lever. Between the truant officer, the school nurse, and the medical inspector with his power of exclusion, a child excluded for such a remediable condition as filth or pediculosis stands surrounded by the devil, the deep sea and the Juvenile Court.

As much as has been already accomplished in Baltimore by school inspection, it is not to be supposed that the present system is a perfect one, and that there is no need for further extension and improvement. The policy of the Health Department has been to make a small beginning, to feel its way carefully, and to extend the work according to local needs. In many respects we have problems peculiar to us to deal with in Baltimore, and while the experience of a city like New York may help us, it can also mislead us in working out details. In New York there are over 50 medical inspectors to look out for 700,000 school children, yet in New York thorough and frequent inspection is a much simpler problem than here, as the schools are very much larger, often 5000 or 6000 children under one roof, with perhaps not more than three or four schools quite near together in charge of one inspector, so that daily early morning visits to all his schools are possible. In Baltimore, with very much smaller schools and a much less congested population, one inspector may have 20 schools widely separated in his

charge. My own district extends from Columbia avenue to Forest Park and Arlington. An increase in the number of inspectors will render more frequent visits possible. In my opinion, 6000 or 7000 children would be a sufficient number under the care of an inspector in the ideal system.

Medical inspection in the public schools has come to stay. It is no longer an experiment. It meets with the hearty approval of the public. Not only the great cities have adopted it, but it is rapidly being introduced into the smaller towns, and even into rural communities. Not only as a preventative in the spread of contagious disease, but from the standpoint of its educational value in matters of hygiene and cleanliness, it is becoming a great factor in promoting the public health. If in pointing out the aims and methods of our work to the city members of the Faculty I am able to bring about a closer reciprocity between the profession at large and the inspectors, much good will have been accomplished. If I shall also be able to interest the county members in the subject, and so hasten the adoption of school inspection in the State outside of Baltimore, I shall indeed feel that your time has not been wasted. The problems are somewhat different in the counties, but the difficulties can be met and overcome.

PARTIAL ANALYSIS OF CASES OF TYPHOID FEVER IN 1906.

By C. Hampson Jones, M.D.,

Assistant Commissioner of Health; Professor of Hygiene and Public Health, College of Physicians and Surgeons.

In presenting to you a partial analysis of the reported cases of typhoid fever in Baltimore during the year 1906 it will be of some interest first of all to review by means of a table the number of cases arranged according to years and months, from 1897 to 1905, inclusive, a period of nine years. Based upon this table I have constructed charts to show the rise and fall of the number of cases of typhoid fever.

The first chart shows the number of deaths and the number of cases of sickness due to typhoid fever; also it shows the estimated number of cases of typhoid fever during the same period. The basis for this estimation is the number of deaths, which are supposed to be about one death in 10 cases of fever.

It is gratifying to note that while at the beginning (1895) of the period of compulsory notification of the Health Department of such cases of fever the percentage death rate to the number of reported cases was a fraction over 66 per cent., the rate improved year by year up to the present time, and in 1905 the death rate was a fraction over 19 per cent.

The second chart has been made to show, first, the average

number of cases of typhoid fever reported in each one of the 12 months of the year during years from 1897 to 1905, inclusive; also the average estimated number for each of these months, and finally by the interrupted line is represented the actual number of reported cases each month for 1906.

I present also copies of maps, which show the location of the cases of fever in 1901, 1902, 1903, 1904 and 1905, which as a rule show that the reported cases are fairly equally distributed over the city, but such is not the case in the map showing the cases of fever last year, 1906. In this one we find a great development in the number of cases in the Woodberry and Hampden districts.

This map has been analyzed by taking photographs of the monthly map records, which demonstrate that an outbreak of fever occurred in April and May.

I have analyzed the map record for 1905 in part by photographing the map records for April, May, June, July, August and September, during which time we find no outbreak like that in Woodberry and Hampden in 1906. The first indications of this outbreak were noticed in March, when our system of reports on cases of typhoid fever showed that an unusual number of fever cases were developing among the patrons of one dairyman in Woodberry. About the same time rumors of a case of fever in this same dairyman's family were heard. These rumors caused an investigation to be made, which revealed a convalescent from typhoid fever in the person of the dairyman's granddaughter. Careful inquiry and supervision of the dairy convinced the department that this case could be of no further danger to the people. The investigation brought to light, however, that this dairyman was distributing not only the milk from his own six or eight cows, but also milk from four farmers. With the aid of the State Board of Health, these four farms were investigated, and suspicion fell upon two of them, because the water they were using for cleansing purposes was polluted. The milk from both these farms was stopped from being brought into the city until further investigation could be made. We then found that on one of these farms that not only was there a case of typhoid fever, but that also a case of the same fever had developed in one of the milkers some time before, and was now well; and, furthermore, that probably a case of the same fever antedated that of the milker. This case was in a home located on land much higher than the dairy farm, and the house drainage flowed into a stream of water that was used for cleansing the milk cans and other utensils of the dairy. The closing up of the dairy farm stopped the local epidemic of typhoid fever in Woodberry and Hampden.

Those of you who know the district of the city referred to might think that this epidemic had its cause in the polluted well water that is used in this district. We do not deny that some case or cases of fever might have had such a source, but against this idea is the fact that nine-tenths of the cases of fever were on one man's

milk route, and the other one-tenth on the milk routes of three other dairymen. Then, too, as a further proof that milk was the cause, we have two facts—

First—The high percentage of young persons attacked.

Second—That the milk distributed to other sections of the city by this same dairyman did not develop any fever. We found that this milk came from the other three farms where there was no fever, and that the milk which came from the infected farm was distributed only to the Woodberry and Hampden districts.

I have presented this review to you not only with the hope that it might be of some interest to you, but also for the purpose of recalling to the minds of some of you that a few physicians some two years ago openly expressed their opinions as to the effect that certain cases of typhoid fever were being produced by the milk from a certain large dairy. Their opinion was based on the fact that some ladies employed in a department store were taken sick with typhoid fever, and that the colon bacillus was found in the milk supplied to that store.

I cannot take your time to go into this case in detail, because it has nothing to do with this paper, but I must caution you not to jump hastily at conclusions as to the source of an outbreak of typhoid fever, because, in this particular instance, the milk was not to blame, or else we should have had cases of the fever in most of the 2400 families supplied by this dairy, had the milk been infected, and also because the finding of the colon bacillus in milk is almost constant and means nothing by itself.

Our city presents no barriers to invasion by typhoid fever. The water, milk and raw foods routes are all open, and the amount of typhoid fever that we develop annually depends mainly upon how much the outside world has to give us. When I say that there are no barriers I mean only that none have been erected by the city, because there is one barrier that has done much good, i. e., the enlightenment of the citizens as to the sources of typhoid fever, which has caused them to purchase spring waters or to consume no raw foods, either liquid or solid, more especially during the so-called typhoid months, July, August and September.

It is unfortunate that all cases of typhoid fever are not reported, because it would enable us to be much more positive in our deduction as to the source of the disease. In spite of this drawback, however, which is becoming less every year, I believe it is safe to conclude that our typhoid fever is not commonly milk-borne. This analysis shows the need of the city providing milk-farm inspectors. This need has been shown by other considerations of the milk supply of this city, but when it is possible to produce 150 to 200 cases in one man's milk route, and these coming from one farm, and we consider that there are between 400 and 500, more or less, careless milk producers, it makes the need of supervision all the more urgent.

Society Reports.

BALTIMORE CITY MEDICAL SOCIETY.

SECTION ON CLINICAL MEDICINE AND SURGERY.

MEETING FRIDAY, NOVEMBER 1.

J. W. Williams, Chairman. J. A. Chatard, Secretary.
S. M. Cone, Third Member of Executive Committee.

Inspection and Chemical Examination of the City Milk Supply.—Wm. E. Hoffman, Jr., Ph.D.

WHAT IS BEING DONE.

The Health Department employs two outside inspectors and has a laboratory force of three. This force has been found inadequate for the work in hand. The inspectors work at the railroad stations and inspect as much milk as they can with the lactometer. The lactometer reading is perfunctory at best, but this is all that can be done at present. The inspectors also go around the city looking into the sanitary condition of dairies and wagons. They have authority, by city ordinance, to spill all milk of low standard, the standard being milk having 3 per cent. butter fat, 10 per cent. solids and a specific gravity of 1.029. They also have authority to spill dirty milk and milk in dirty cans. Sample bottles are carried, samples taken, and these are turned over to the laboratory force for analysis with regard to preservatives, fat content, etc.

Last spring 10 to 15 per cent. contained preservatives. Practically 40,000,000 gallons were consumed in the last year, of which 20 per cent. was inspected and .03 per cent. spilled. In the three summer months of 1906 formaldehyde was found in 50 per cent. of the milk. This infraction of the law was unintentional, and when the dealers were told of it the practice dropped off. In 1907 only 3 per cent. of the samples contained preservatives.

There is no prosecution in Baltimore for low specific gravity owing to the difficulty of getting samples from the large cans and because of the cream rising to the surface during the long standing at the stations.

WHAT WE WANT TO DO.

It is desired to increase the force of inspectors by four, making six in all, so that we can have an inspector at each station in the city every morning, and send the remaining two out in the country to inspect farms, wells and water supplies.

The analysis is both chemical and bacteriological. The bacterio-

logical examination is used as a check, since if in the products of two adjoining farms one is found to give a much higher bacteriological content than the other the reason for the difference must be found, and the inspector may warn the farmer. An effort is to be made to get refrigerating cars. It is desirable also to make the dealer responsible for the milk from station to consumer.

Pus counts are made to a certain extent, but with the mixed milk from different herds the results are not very useful. Hereafter it will be tried to get specimens from single herds.

We shall ask the Legislature for a higher standard. For example, the butter fat should be 3½ per cent. Most cows give 3.6 per cent., and hitherto this milk has been diluted down by the dealers to the required minimum per cent., viz., 3 per cent.

The Bacteriological Examination of Milk.—Dr. Wm. Royal Stokes.

TUBERCULOSIS.

The search for the tubercle bacillus is important in the detection of serious milk contamination. The tubercle bacillus is often found in market milk. Bang, Ernst, Hirshberger, Klein and Boyce found tubercle bacillus in 6 to 50 per cent. of samples examined. At Cambridge it was found in 9 out of 16 dairies examined; at Islington 14 per cent. out of 118 samples contained it; at Hadsney 22 per cent., and at Croydon 6 per cent. of 164 milks gave a like result. In 1897 Obermüller found tubercle bacillus in 38 per cent. of Berlin milk, and Martin in 33 per cent. of the market milk of Paris. Swithinbank and Newman found tubercle bacillus in 15 per cent. of 498 samples of butter examined. In our own laboratory the microscopic examination of 400 specimens of milk has revealed only two suspicious bacilli. In the inoculation of guinea-pigs with the sediment of 500 c. c. of milk, 26 intraperitoneally and 12 subcutaneously, none died within two months of tuberculosis, and when killed after two months none showed signs of the tubercle bacillus. The late Professor MacFadyean believed 2 per cent. of milking cows had tuberculosis of the udder. The Sanitary Live-Stock Board of Pennsylvania examined 44,801 cattle and found 12 per cent. tuberculous. It is now definitely established that bovine tubercle bacillus can produce tuberculosis in men. Professor Russell of Wisconsin found that 34 per cent. of 1213 cattle fed on refuse skimmed milk were tuberculous, while only 8 per cent. of 1467 cattle not fed on skim milk were tuberculous.

STREPTOCOCCI AND LEUCOCYTES IN MILK.

In 1897 Dr. Clement called attention to an epidemic of purulent inflammation of the milk canals in a herd of 80 cows. On examination the milk from nearly all showed leucocytes and streptococci

in large numbers. In the examination of other individual cows the sediment from 10 c. c. of milk showed quantities of pus cells varying from none to 158 in each field of the oil immersion lens.

Dr. Slack of Boston has been able to trace out cases of garget or purulent inflammation in cows, where leucocytes and streptococci have been found in excessive numbers. It should, however, be remembered that healthy cows at times secrete large numbers of leucocytes and that the streptococcus is often a normal inhabitant of the milk canal. Nevertheless, cattle showing excessive numbers of pus cells and streptococci should be isolated till examined by a veterinarian and pronounced healthy.

Doane and Budsley of the Maryland Agricultural College use the Thoma-Zeiss blood counter, and believe that cows having over 500,000 leucocytes to 1 c. c. should be isolated and carefully examined for garget. Since 1897 the Health Department has found excessive leucocytes in the milk of 85 cows examined. Most of these showed inflammation of the udder and were excluded from the milch herds.

NUMERICAL ESTIMATE OF BACTERIA AND DETECTION OF THE COLON BACILLUS.

Milk obtained under ideal conditions often shows less than 10,000 bacteria to the cubic centimeter, while dirty milk may run as high as 100,000,000 bacteria to the cubic centimeter. Hewlett and Barton found the colon bacillus in 46 per cent. of London milk samples in quantities not exceeding 1 c. c., and total bacteria counts of 20,000 to 8,000,000 per cubic centimeter. In one of every 26 specimens the tubercle bacillus was detected and the animal condemned. Park in 1901 in New York found 5,000,000 bacteria per cubic centimeter on the average in milk at railroad stations, increasing to 15,000,000 in the poorer districts. The presence of the colon bacillus is regarded as an indication of contamination by stable dust. In 1900 this bacillus was found in 24 per cent. of samples of Liverpool milk. Jackson of Brooklyn reported the presence of the colon bacillus in quantities as small as one-tenth of a cubic centimeter.

In 1906 we made 685 bacteriological examinations of milk:

100	samples contained	10,000	to	50,000 bacteria.
58	samples contained	50,000	to	100,000 bacteria.
124	samples contained	100,000	to	500,000 bacteria.
60	samples contained	500,000	to	1,000,000 bacteria.
244	samples contained	1,000,000	to	10,000,000 bacteria.
89	samples contained	10,000,000	to	50,000,000 bacteria.
10	samples contained	50,000,000	bacteria or over.	

In milk containing 1,000,000 or under of bacteria the colon bacillus was found 103 times in 1/1000 of a cubic centimeter, and

not found 244 times, or found in 29 per cent. and absent in 71 per cent. But in milk running over 1,000,000 bacteria to the cubic centimeter the colon bacillus was found 245 times and absent only 93 times, or present in 72 per cent. and absent in 28 per cent. This shows that the colon bacillus is more apt to be present with a high bacterial count.

The colon bacillus was found in only 15 per cent. of 27 certified milks examined. The highest average bacterial counts occur in late summer:

	Jan.	Feb.	Mar.	Apr.
Average bacterial count.	6,280,000	3,600,000	1,700,000	2,800,000
Infant mortality from intestinal diseases.....	5	6	4	2

	May.	June.	July.	Aug.
Average bacterial count.	3,400,000	....	5,000,000	5,500,000
Infant mortality from intestinal diseases.....	14	70	269	121

	Sept.	Oct.	Nov.	Dec.
Average bacterial count.	14,500,000	7,000,000	4,800,000	3,800,000
Infant mortality from intestinal diseases.....	77	37	11	7

No correspondence between high counts and infant deaths is shown by this table.

The colon bacillus was found in only 17 per cent. of milk examined from January 1 to May 31, but was found in 75 per cent. of examinations from June 1 to October 31.

The diphtheria bacillus has been rarely isolated from milk, and the typhoid bacillus never. Thus it will be seen that the bacteriological examination of milk is useful mainly in studying the general condition of the milk supply, and that we must depend on careful inspection and well-administered laws to prevent the numerous milk-borne diseases.

Pasteurization.—Dr. M. J. Rosenau, Washington, D. C.

Pasteurization consists of heating to a point below the boiling point and chilling rapidly. Pasteur did his work on wines and thus demonstrated the law. Beer heated to 55° C. undergoes no abnormal fermentation. This has given us the term. At first the object of heating milk was to preserve it, but now this is done to destroy the pathogenic organisms and their poisons.

In 1882 or 1884 Stockley advocated the heating of milk for infants. At first the milk was boiled to sterilize it, but Pflügge showed that boiling does not remove all danger, as the unkilled spores can produce poisons. It was also found out that heating to a high temperature changes the milk, chemically and physically,

rendering it less digestible, favoring constipation, and if its use be long continued favoring scurvy.

ADVANTAGE OF PASTEURIZATION.

Harm is done by misapplication of this term. Pasteurization does not make high-grade or clean milk. It means simply heated milk. We should define the term by stating the length of time of heating the milk and the date on which it was done. Pasteurization is an expedient, not an ideal, just as antisepsis was an expedient in surgery, while asepsis is the ideal. Clean milk is the end we seek. Milk can be very healthful or very poisonous, and can convey diseases as well as poisons.

Heated milk is good for children above three years old and for adults, but not for infants.

It is difficult to produce milk clean and pure. Even when it is certified, milk cannot be kept pure. We should have a safe product; milk should be milked clean and then kept clean.

IS THE USE OF RAW MILK RIGHT?

In Washington it has been shown that 10 per cent. of all typhoid is due to milk. Last year there were three outbreaks due to milk, with a total of 87 cases, while this year there has been one outbreak, with 28 cases. It is felt that even more than 10 per cent. of typhoid fever is due to milk, but this is difficult to trace up and prove. There have been similar outbreaks in other cities. In Germany and France typhoid is not chargeable to milk, as all milk used there is boiled. In Washington last year market milk contained 22,000,000 bacteria to the cubic centimeter, while this year it contained 11,000,000. The milk supply of Washington comes from 1000 farms. In Boston some of the farms are from 40 to 100 miles distant. New York uses 1,500,000 gallons a day, handled by 35,000 retailers. Pasteurization saves lives and prevents sickness.

DISADVANTAGES.

Theoretically, pasteurization is unsatisfactory and feeble; practically, it is our only safeguard. It is said to promote carelessness and encourage dirty habits in farmers. Pasteurization should not take the place of inspection, and the milk should be tested chemically and bacteriologically. The health officers should be empowered to condemn and destroy bad milk. The producers must be skilled and should be subject to thorough inspection.

Pasteurization does not make milk better as a food, but it does destroy some bacteria.

The results at Washington indicate that heating to 60° C. for a period of 20 minutes gives the best result. Milk thus treated contains bacterial toxins and spores, but the enzymes are not killed.

Sterilization devitalizes milk. The life is lost at from 24 to 48 hours and the milk contains bacteria. Much of the milk in Washington is from 24 to 36 hours old. Fresh milk is germicidal and stays so for about eight hours. Very much fewer bacteria grow on agar from milk of this age and from pasteurized milk. The objection to the 60° method is that bacteria and toxins are not all killed at this temperature. The acid-producing bacteria are killed and the milk may be spoiled, though it appears sweet to the user. The peptonizing bacteria are not killed by heating.

Some people say, "Don't meddle with nature," but nature never meant milk to be carried long distances, and infants must be fed on cow's milk transported for long distances. All milk does not need pasteurization, but under existing conditions pasteurization affords substantial protection to the consumers of milk.

The Municipal Control of the Milk Supply.—Dr. C. Hampson Jones.

Much attention has been directed to this subject since the passage of the pure-food law. Bolla of Rochester and Darlington of New York, as well as others, have considered the question in all its aspects and departments. We are confronted with two facts—dirty milk is dangerous to health; pure milk is hard to obtain after delivery; that is, the delivery of pure milk is difficult.

In 1888, Chapter 519, Article 58, provided for the establishment of the State Live-Stock Board. The above was extended by Chapter 306: "All dairymen to be fined not less than $1 nor more than $20 for each offense. Premises to be inspected once a year and to be closed if not conforming to the following rules:

"1. Sheds to be well lighted and to have good floors, well drained.

"2. No privies in stables of dairy cows; no other animals to be in these stables.

"3. Premises must be clean and kept painted.

"4. Buildings to be cleaned and dung removed.

"5. Receptacles to be of non-absorbent material and kept clean.

"6. Cows to have clean feed and pure water to drink.

"7. Stalls to be bedded with straw; no drains near them."

A fine of from $1 to $20 was provided for each day after notice. Dairymen must have a certificate of health and these are revocable. Three thousand dollars was appropriated to carry out these rules and enforce them.

These rules are unknown at large, and bad conditions exist in stables in spite of these laws. The State Board is not to blame. The execution of these laws is important. The officers must have the means to carry them out. The magistrates must know the law in order to obtain convictions and enforce it. At present there are more convictions in Baltimore than elsewhere in the State. The Mayor and City Council are responsible for the health of the city.

The city laws are the same as the State laws. The tuberculin test is used, and the Commissioner of Health is notified in the case of sick cows.

We must provide by law that the milkers and cows shall be clean; that no preservatives or coloring matter shall be used; milk shall not be removed from one can to another; that we shall have a standard of contents, and, finally, special legislation recognizing buttermilk and skim milk; also that we must have samples of all milk taken and analyses made.

At present the law provides for three milk inspectors, one chemist and assistant and one inspector of cow stables. This, with the chief, gives a force of seven men. Six additional inspectors are asked for, and it is proposed to license dealers and dairymen.

The dealers are prosecuted for preserving with formaldehyde, while really the producers did it. A committee of two has been appointed to look into the matter.

The proposed ordinance provides:

1. Milk dealers to apply to Commissioner of Health for permit.
2. Result of inspection to be satisfactory for issue of permit.
3. Dealers to send to Commissioner of Health list of the consignors of the milk they handle.
4. Penalties for violations of ordinance.
5. Bottles to be cleaned.
6. Milk not to be transferred from can to can in milk wagon.

The producers must be taught how to fulfil conditions of the above and then prosecuted for wilful neglect. It is proposed to inspect farms and stables in the counties and instruct the owners. Then if it is found that the producer cannot and will not meet requirements, exclude his milk from the market. Thus both mortality and morbidity will be lowered. The consumer must be educated by physicians and nurses, and thus even more good will be done.

DISCUSSION.

Dr. Knox: At the Wilson Sanitarium milk is produced under ideal conditions, often showing under 100,000 bacteria to cubic centimeter; yet with a defective refrigerator in one of the wards, in from 16 to 24 hours on warm days the milk ran up to 1,000,000 bacteria to cubic centimeter. Refrigeration is important, especially immediate cooling. This applies even more particularly to the poor. Low-count milk (1000 to 5000) will be unsuitable in from 16 to 24 hours for infant feeding in going to the poor. It has been noted that pasteurized milk stayed sweet, while raw milk did not. A low temperature is important in pasteurization. From 110° to 170° used to be the temperature; now 55° to 60° for 20 to 30 minutes is used. The poor should be taught to pasteurize the milk. Boiled milk is not good for infants.

Dr. Watson: Does Dr. Rosenau advocate the general pasteurization of the milk supply at farms and dairies?

Dr. O'Donovan: Producing pure milk is expensive, and we must pay more for milk. Individuals must insist on getting pure milk. We get as good milk as we demand and pay for.

Dr. C. U. Smith reported two cases of infantile scurvy with pasteurized milk and several cases with sterilized milk.

Dr. Jones: The details of cooling were purposely avoided in the paper. A movement is now on hand looking to city cooling. The city will try to get the milk to the consumer at 50° F. The dangerous milk is not railroad milk, but suburban milk. The city milk situation is somewhat controlled. The wagon-brought milk is the worst, and an effort is to be made to wipe out some suburban dairies. Rural milk is high in bacteria count, but good. It is to be wished that rural milk could be tested before going to the consumer. It is thought that dirty methods often are in the house. In Baltimore there is milk that a physician can recommend. Pasteurization cannot be done by the city, but must be done by the distributer. The worst milk is not pasteurized.

Dr. Rosenau: The quality of milk in Baltimore is not much better than in Washington. In Washington the physician can point to *no* safe milk, *i. e.,* certified as to proper dairy methods. Therefore, since we have no milk to be relied upon, and much dirty, stale milk, the physician must heat the milk and destroy, at least, some of the poisons. Milk is best heated just before it is used; next best thing is to heat the milk at the farm and then keep it clean.

Pasteurization is a difficult business technically. In Washington, with a good Pasteur plant and poor help, the milk contains more bacteria after the operation than before. If the help is pretty good, 98 per cent. of bacteria are removed; if the labor is skilled, 99 per cent. of bacteria are removed. The best plan is to pasteurize, under the Health Officer, at different central points in the city. If done at the farm, the operation is too spread-out. There are other factors in scurvy besides heated milk. In French dispensaries there is very little scurvy with highly heated milk; in Germany none at all. Perhaps scurvy is not recognized there. Lately some cases have been reported in France. At 60° 20 minutes gives no physical chemical change, though the bacteria are killed.

MARYLAND MEDICAL JOURNAL

JOHN S. FULTON, M.D., *Editor*

Associate Editors:

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BALTIMORE, DECEMBER, 1907

WATCH IT GROW.

THE Medical and Chirurgical Faculty of Maryland is watching a sum of money grow. The word passes round continually, "WATCH IT GROW," for by concentrating the interest of the profession on the gradual accumulation it is possible to arouse a common desire to MAKE IT GROW. The amount to be raised is $50,000, a sum which must seem rather large, for the average physician knows hardly anything about joint enterprises, and when he goes into them, does so, as a rule, on the advice of someone whom he trusts, without informing himself about the particulars. The MARYLAND MEDICAL JOURNAL is by no means a guide to investors; its opinion would in general be worth less than the cost of stating it in print. But the present undertaking of the Medical and Chirurgical Faculty is so sound that even the JOURNAL may recognize and proclaim its merits.

FOR OUR OWN GOOD.

FIFTY THOUSAND DOLLARS, they say, are needed for a building fund. If the present building does not afford space enough for the regular meetings of the Faculty or of its local constituent societies, that circumstance alone would justify the call for whatever sum is needed to provide adequate space. Since the business of the Faculty is the business, not of a chosen few, but of all the members, it would seem a prime essential that the concern should guarantee to every member room to sit comfortably at every meeting. Inadequate space curtails the power of the Faculty to deal with its current problems, it discourages attendance, it checks growth, it prevents expression of the society's will, it favors poor administration of the Faculty's affairs. The Faculty outgrew its present quarters years ago and now depends on the hospitality of its friends, not only for the annual meetings, but for many of the meetings of local societies. The meeting at which the

election of officers takes place is so severe a tax on the physical endurance of the members that many men absent themselves on that account. It is a physical impossibility for more than one-third of the membership of the Faculty to cast their ballots at an annual election. A business association in like case would provide adequate quarters by means of an assessment or a loan. An assessment of $50 or an annual tax of $3 would bring the money which the Faculty needs.

SEEKING THE GOOD WHICH IS NOT OUR OWN.

In the past 10 or 15 years a good many enterprises of public moment have been started by the medical profession, their inception having been prepared in our own building. But it has not been possible to bring any of these things definitely into the field of public discussion from the Faculty's own forum. The plan to give the work of the Sewerage Commission an open discussion and a strong impetus was prepared in the Faculty Hall, but the meeting at which Mr. Mendes Cohen and Col. George E. Waring spoke did not take place in the Faculty Hall. The medical inspection of schools, the public baths, State care of the insane, the antituberculosis campaign, the movement to repress the social diseases, the milk campaign and other beneficent schemes were incubated in the small building on Hamilton terrace. Many of these enterprises grew to be permanently self-supporting and some of them now have houses of their own. But they did not see light in the Faculty rooms and the records do not trace them to the humble locality where they actually became viable. Perhaps someone may say that we have done well enough both for ourselves and for the public, and should be congratulated whenever the good that is born of us outgrows us; but, on the other hand, we can be sure that whatever we bring forth for the public good ought to be nourished by us at least through its infancy. Not all of our offspring have done well. Moreover, it is of some concern to us that what we have generated shall be commonly acknowledged as ours. Our house is so small that we cannot brood all our chicks at home, but we want to, or we ought to want to, and we will if normal instincts prevail over material difficulties.

OUR TRUSTEESHIP.

The call for a sum of $50,000 expresses much more than a need of the medical profession, but we are immediately concerned with the need of a new building, and our argument is limited to the medical man's interest in this investment. The vision of a new, commodious and comfortable home is of itself sufficiently alluring, but this prospect does not reveal the economic merits of our present effort. Above considerations of physical comfort and of social propriety we have found spheres of public and pro-

fessional utility, in which, for want of house room, we are less efficient than we should be. We need this money in order to liberate our moral, social and civic powers as well as our technical abilities. We shall not try to compute, much less to state, in units of value the equivalents of these energies. Having only narrow ends in view, it would pay to scatter coin for the sake of increasing the productiveness of such assets.

But beside these two considerations, and as good as the better of them, we owe at least $50,000 on account of our actual material holdings. When we say that we have realty worth $15,000 we have said as little as possible about our material resources. We are trustees of the property accumulated during more than a century by our fathers. The contents of our house on Hamilton terrace are literally invaluable. If destroyed, as they might easily be by fire, the loss would be irreparable and beyond calculation. Three thausand dollars a year would be well spent to guarantee its preservation on account of its historic value. Fifty thousand dollars would afford us very poor consolation if this collection were lost.

Rich as they are in historic and sentimental value, the contents of our building are chiefly valuable as live material for working-day use. Here is a living, growing collection of books, unfavorably planted, suffering from insufficient sunshine, not able to send roots downward or to bloom upward as a well-housed, well-tended library should. By unfavorable surroundings potential wealth is restrained in the development of actual wealth.

The story of our unwise hoarding is not yet complete. We have some $20,000 which have come to us as expressions of affection for two men of our day, one passed on forever, and the other living, but absent. To this we should add the cash equivalent of the moneys paid into the treasury each year. A payment of $7 signifies a proprietary interest in the concern amounting to about $116; a payment of $3 means a permanent interest worth about $50. Figuring on a stable membership (it is really a growing one), we should find that a practical capitalization of our business would run into figures which outrun the sober experience of the average physician. Here, then, is what the call for $50,000 means: It means that we are dealing with our valuable concern, not as a going concern, but rather as an unconcern; it means that we of our day have not paid any inheritance tax. We have put our heritage away in a napkin. We are idle toward our greater tasks, though good enough for an ordinary day's work. We have not realized our worth nor realized upon our worth. The call for $50,000 means no more than to raise our working power from 45 pounds to 50 pounds, adding 11 per cent. to power and quadrupling our output. It means the conversion of potential wealth into actual wealth; and this is an appeal, not so much to the man who can afford to leave capital idle, as to the man who must make every dollar work. These are the great majority, and it it to them especially that the call comes on its merits as profitable investment, enabling them to realize on potential capital which belongs to them, and needs only to be unlocked in order to assume its proper function as a live asset.

Medical Items.

BALTIMORE.

Dr. Howard A. Kelly was tendered a reception at the home of Dr. George H. Noble of Atlanta, Ga., on Friday evening, November 1. A large number of prominent physicians in Atlanta were present and several interesting addresses were given. On Saturday morning Dr. Kelly held a clinic at the Atlanta College of Physicians and Surgeons, and in the afternoon he held another at the Atlanta School of Medicine.

Dr. Francis M. Chisolm has been recently appointed associate professor of ophthalmology in the Medical School of the University of Maryland. A systematic examination of sight and hearing of the students of St. John's College, the academic department of the university, is being conducted by Dr. Chisolm. Dr. Chisolm has resigned from the staff of the Presbyterian Eye, Ear and Throat Charity Hospital of Baltimore and is no longer connected with that institution.

A sneak-thief operated for a few days recently in the northern section of Baltimore with considerable success. He confined his adventures to the offices of physicians. His scheme was an old one. He called when the physician was likely to be out, and, being admitted, he asked leave to write a message; then he asked for a drink of water. Being left alone for a minute or two, he made a hasty search for money or valuables. At one physician's office he asked for hot water, saying that the physician was at the time treating him for stomach trouble and required him to drink hot water at certain intervals. The thief got only postage stamps to reward him for this ruse. His depredations were promptly reported to the police, and the thief vacated the field without leaving his address. A little later the following story was reported from Brooklyn:

"A man, said to be about 36 years of age and 5 feet 10 inches in height, with dark complexion and hair, is being sought by the police for having last week robbed the office of a Brooklyn physician. The thief called during the doctor's absence, and at the servant's suggestion sat down to wait his return. He promptly disappeared after having entered several rooms in the house and abstracted jewelry, etc., to the value of $1000."

GENERAL.

A bill which gives the Illinois State Board of Health power to regulate and control medical colleges and to determine the educational qualifications of applicants for admission to medical colleges was recently passed by the Senate by a vote of 36 to 1.

Dr. Samuel G. Dixon, Commissioner of Health for Pennsylvania, is establishing a dispensary for tuberculosis in every county in the State in accordance with the law recently passed. In Philadelphia the dispensary, in charge of Dr. Alfred Stengel, will be the center from which various parts of the city may be easily reached.

The committee on the prevention of tuberculosis of the Charity Organization Society of New York announce that the first season of the old Staten Island ferryboat Southfield as a hospital for the treatment of tuberculosis patients was a success. The hospital was in operation from June 13 to October 31, and during that time 242 patients were treated.

At a recent meeting of the Syracuse Academy of Medicine Dr. Joseph C. Bloodgood, professor of surgery at the Johns Hopkins School of Medicine, delivered a lecture on "Diseases of the Thyroid Gland," which was illustrated with stereopticon views. At the close of the meeting a reception and banquet were given Dr. Bloodgood, at which he gave a short talk on the "Advantages of Experimenting in Medicine and Surgery."

On November 4 Dr. Carlos Finlay, chief of the Department of Health and Sanitation of Havana, was presented by Governor Magoon with the Mary Kingsley medal in recognition of his work in connection with the transmission of yellow fever by mosquitoes. The medal is awarded by the Liverpool School for the Study of Tropical Diseases to commemorate Miss Mary Kingsley, the African traveler.

The German medical press will soon be free from a nuisance which affects medical journalism everywhere, though it prevails most in Germany. The fake medical authors are to be blacklisted. With the assistance of the more important chemical houses the German Medical Editors' Association is preparing a list of the physicians who write articles recommending new remedies and receive pay for such services. The German medical editors will not

print, abstract nor otherwise notice articles written by such authors.

In its last monthly bulletin the New York State Board of Health makes the following statement in regard to cancer: "The cancer problem is assuming more and more menacing proportions, there being reported 572 deaths from this cause in September, 1907, as against 526 in the same month last year and an average for five years of 456. Thus, while deaths from tuberculosis are held practically stationary, we are doing nothing to hold cancer in check as a cause of mortality."

Mr. Victor G. Bloede has offered to give $25,000 to the trustees of Eudowood Hospital for Consumptives for the purpose of erecting an additional building. The gift is conditioned on the raising of a sufficient sum to maintain the new hospital for three years. The collection of such a sum is supported earnestly by the Baltimore newspapers, and one must most earnestly hope that the additional sum will be forthcoming. The plan is to provide for the care of advanced cases, and a stronger appeal than this could hardly be made to the charitable public.

The national committees on the International Congress on Tuberculosis are being appointed. The American committee of arrangements has referred this matter to three men in each country, and reports are beginning to come in. The Swedish committee has organized with Dr. Bertil Buhre as chairman and Dr. Klas Linroth as secretary; the Norwegian committee has organized with Dr. Michau Holmboe as chairman and Dr. F. Harbitz as secretary; the Danish committee has organized with Dr. C. J. Salomonsen as chairman and Dr. Bang as secretary; the German committee has organized with Dr. Von Leyden as chairman and Dr. Wietner as secretary; the national committee for Greece has organized with Dr. Kalliontzis as chairman and Dr. Patrikios as secretary; the Holland committee has organized with Dr. P. K. Pel as chairman and Dr. Vos as secretary; the Cuban committee has organized with Dr. Juan Guiteras as chairman and Dr. Mario G. Lebredo as secretary.

The executive committee of the American National Red Cross adopted the following resolutions on October 18, 1907:

Whereas, by international agreement in the Treaty of Geneva, 1864, and the Revised Treaty of Geneva, 1906, "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross" were adopted to designate the personnel protected by this convention; and

Whereas, the treaty further provides (Article 23) that "the emblem of the Red Cross on a white ground and the words Red Cross or Geneva Cross can only be used, whether in time of peace or war, to protect or designate sanitary formations and establishments, the personnel and material protected by this convention;" and

Whereas, the American National Red Cross comes under the regulations of this treaty according to Article 10, "volunteer aid societies, duly recognized and authorized by their respective Governments," such recognition and authority having been conferred upon the American National Red Cross in the charter granted by Congress January 5, 1905, Section 2, "The corporation hereby created is designated as the organization which is authorized to act in matters of relief under said treaty;" and, furthermore,

Whereas, in the Revised Treaty of Geneva, 1906, in Article 27, it is provided that "the signatory powers whose legislation should not now be adequate engage to take or recommend to their Legislatures such measures as may be necessary to prevent the use by private persons or by societies other than those upon which this convention confers the right thereto of the emblem or name of the Red Cross or Geneva Cross," be it

Resolved, That the executive committee of the American National Red Cross requests that all hospitals, health departments and like institutions kindly desist from the use of the Red Cross created for the special purpose mentioned above, and suggests that for it should be substituted some other insignia, such as a green St. Andrew's Cross on a white ground, to be named the "Hospital Cross," and used to designate all hospitals (save such as are under the medical departments of the army and navy and the authorized volunteer aid society of the Government), all health departments and like institutions; and, further, be it

Resolved, That the executive committee of the American National Red Cross likewise requests that all individuals or business firms and corporations who employ the Geneva Red Cross for business purposes kindly desist from such use, gradually withdrawing its employment and substituting some other distinguishing mark.

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